Methods and Standards Governing Payment
For
Nursing Facility Services

CASE-MIX PAYMENT SYSTEM

Pennsylvania has established its Medical Assistance Long Term Care Program based on resident characteristics and the specialized service needs of the residents. Nursing facility care is part of the long term care continuum, providing care to recipients whose medical needs do not require intensive hospital care, but need a higher level of care than that provided in a non-nursing facility setting. Effective January 1, 1996, the Department reimburses MA nursing facility providers under a prospective case-mix payment system.

Effective July 1, 2006, the Department will reimburse county MA nursing facility providers in accordance with State regulation 55 Pa. Code Chapter 1189 (relating to county nursing facility services) and the approved Pennsylvania State Plan under Attachment 4.19D, Part 1A.

The case-mix payment system has two major components: a system of resident classification and a system of price and rate setting. The case-mix payment system uses a comprehensive automated database, known as the Nursing Information System (NIS) to classify nursing facility residents and to determine nursing facility payment rates.

A. Resident Classification System

The first component of the case-mix payment system is the resident classification system. The case mix payment system uses the Resource Utilization Groups, Version III (RUG-III) nursing CMI scores to classify nursing facility residents. Nursing facilities submit resident assessment data necessary for the CMI report to the Department as specified in the *Resident Data Reporting Manual*. Taking this data, the Department classifies each resident into the highest RUG-III value for which he qualifies, and calculates a quarterly MA case-mix index and an annual total facility case-mix index for each nursing facility. The Department uses these indices to determine annual peer group prices for each price setting period and to make quarterly rate adjustments for each rate setting period.

Nursing facilities shall maintain hard copy records for a minimum of four years following submission of the resident data. All nursing facility resident records are subject to periodic verification and audit by the Department.

B. Price and Rate Setting System

The second component of the case-mix payment system is the price and rate setting system. The Department calculates annual prices for each nursing facility peer group. In addition, the Department sets annual rates for each nursing facility. To calculate the annual peer group prices and individual nursing facility rates, the Department first uses the NIS database to select a database for the price setting period.

The database includes audited allowable costs. Allowable costs are defined and are identified in 55 Pa Code §§ 1187.2 and 1187.51 respectively.

1. The Database

a. Year one

For year one of implementation, January 1, 1996, through June 30, 1996, the database includes the most recent audited MA-11 cost report for each nursing facility that is issued by the Department on or before March 31, 1995, adjusted for inflation.

b. Year two

For year two of implementation, July 1, 1996, through June 30, 1997, the database will include the two most recent years audited MA-11 cost reports for each nursing facility that are issued by the Department on or before March 31, 1996, adjusted for inflation.

c. Subsequent fiscal periods

Beginning July 1, 1997 and each subsequent Commonwealth fiscal year thereafter, the database will include the three most recent years audited MA-11 cost reports for each nursing facility that are issued by the Department on or before March 31 of each July 1 price setting period, adjusted for inflation; provided, however, that if a nursing facility submits an acceptable cost report to the Department and the Department fails to audit the cost report within 15 months from the date of acceptance, the Department will include in the cost database the nursing facility's

reported costs, as adjusted to conform to Department regulations, for that unaudited cost report period until the audit has been completed.

d. Transition

For net operating prices effective on or after July 1, 2001, the Department will revise the audited costs of cost reports in the NIS database for fiscal periods beginning prior to January 1, 2001 by disregarding audit adjustments disallowing or reclassifying to capital costs, the costs of minor movable property (as defined in § 1187.2, effective on July 1, 2001) or linens reported as net operating costs. The Department will not adjust the audited statistics when revising the nursing facility audited Resident Care, Other Resident Care and Administrative allowable costs to disregard the audit adjustments relating to minor movable property and linen costs. After revising the audited costs to disregard these adjustments, the Department will recalculate the maximum allowable administrative cost, and will disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i).

e. Inflation Factor

The Department trends the cost in the database forward to the midpoint of the year for which the prices are being set using the first quarter issue of the CMS Nursing Home Without Capital Market Basket Index.

2. Peer Grouping

After the Department selects the database for the price setting period, the Department classifies each participating nursing facility into one of 14 peer groups for net operating price setting. The Department classifies facilities that meet the Department's definition of hospital-based nursing facility and special rehabilitation facility into two separate statewide peer groups. To establish the 12 remaining peer groups, the Department will use the MSA group classification issued by the Federal Office of Management and Budget in the Office of Management and Budget Bulletin No. 99-04 to classify each nursing facility into one of three MSA groups or one non-MSA group. The Department then uses the bed size of the nursing facility on the final day of the reporting period of the most recent audited MA-11 cost report in the NIS database to classify the nursing facilities into one of three bed size groups. These groups are 3 – 119 beds; 120 – 269 beds; and 270 beds and over. Except for the hospital-based nursing facility and the special rehabilitation

facility peer groups, the Department will collapse a peer group with fewer than seven nursing facilities into the adjacent peer group with the same bed size. If there are two adjacent peer groups with which to merge, the peer group with fewer than seven nursing facilities will be collapsed into the peer group with the larger population MSA group.

For rate years 2009-2010, 2010-2011 and 2011-2012, county nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv) (relating to peer grouping for price-setting).

For rate year 2012-2013 and thereafter, county nursing facilities' allowable MA costs will not be used in the rate-setting process for non-public nursing facilities.

For the period commencing November 1, 2011, peer group medians and prices will be established for facilities classified as special rehabilitation facilities on or before July 1, 2000 separate from any other facilities meeting the definition of a special rehabilitation facility; facilities classified as special rehabilitation facilities after July 1, 2000 will have peer group medians and prices established using data from all facilities meeting the definition of a special rehabilitation facility. For the period November 1, 2011 through June 20, 2012, this change in peer group methodology will not be a factor in the quarterly BAF calculations.

3. Peer Group Price and Net Operating Rate Setting

Once the Department classifies nursing facilities into the appropriate peer groups, the Department then calculates the prices for each peer group. Under the case-mix payment system, nursing facility net operating costs are separated into three cost centers: resident care cost center, other resident related cost center and administrative cost center. The Department sets prices for each cost center and peer group on an

annual basis. After it sets the peer group prices, the Department uses the prices to calculate rates for the three net operating cost centers for each nursing facility.

a. Resident Care

To calculate the resident care cost medians and prices, the total resident care cost for each cost report is divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year. The Department divides the case-mix neutral audited allowable resident care costs for each cost report for each nursing facility by the nursing facility's total audited actual resident days for each cost report year to obtain each nursing facility's case-mix neutral resident care cost per diem for each cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

The Department arrays the average resident care cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.17 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price for each peer group will be the phase-out median as determined in accordance with paragraph d. below.

The Department calculates each nursing facility's resident care rate by determining the lower of the nursing facility's resident care peer group price or 103% of the nursing facility's case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility peer group price. The Department then adjusts the rate each quarter by multiplying the rate by the nursing facility's MA case-mix index (CMI) to set the facility specific rate for resident care.

For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the resident care rate used to establish each nursing facility's case-mix per diem rate will be a blended resident care rate.

(i) The facility's blended resident care rate for the 2010-2011 rate year will equal 75% of the facility's 5.01 resident care rate calculated in accordance with subparagraph (iv) plus 25% of the facility's 5.12 resident care rate calculated in accordance with subparagraph (iv).

(ii) The facility's blended resident care rate for the 2011-2012 rate year will equal 50% of the facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 50% of the facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iii) The facility's blended resident care rate for the 2012-2013 rate year will equal 25% of the facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 75% of the facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iv) For rate year 2010-2011 each nursing facility's blended resident care rate will be determined based on the following calculations.

(A) For the first quarter of the rate year (July 1, 2010 – September 30, 2010) the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with § 1187.96(a)(1)-(5) (relating to price and rate setting computations). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility in accordance with § 1187.96(a)(1)-(5) (relating to price and rate setting computations). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.01 44 group values. The resident assessment that will be used for each resident will be the most recent comprehensive resident assessment.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2010 and ending September 30, 2010 will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.75 and the nursing facility's 5.12 resident care rate multiplied by 0.25.

(B) For the remaining three quarters of the 2010-2011 rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30) the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with § 1187.96(a)(5) (relating to price and rate setting computations). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the facility's prior quarter 5.01 resident care rate by the percentage change between the facility's current quarter 5.12 resident care rate and the facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the facility's current quarter 5.12 resident care rate by the facility's previous quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the three remaining quarters of the rate year will be the sum of the facility's quarterly adjusted 5.01 resident care rate multiplied by 0.75 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.25.

v) For rate years 2011-2012 and 2012-2013 each nursing facility's blended resident care rate will be determined based on the following calculations.

(A) For the first quarter of each rate year (July 1 – September 30) the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with § 1187.96(a)(1)-(5) (relating to price and rate setting computations). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility by multiplying the facility's prior April 1st quarter 5.01 resident care rate by the percentage change between the facility's current 5.12 resident care rate and the facility's prior April 1st quarter 5.12 resident care rate. The percentage change will be determined by dividing the facility's current 5.12 resident care rate by the facility's April 1st quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2011 and ending September 30, 2011, will be the sum of the facility's 5.01 resident care rate multiplied by 0.50 and the facility's 5.12 resident care rate multiplied by 0.50.

(IV) The nursing facility's blended resident care rate for the quarter beginning July 1, 2012 and ending September 30, 2012, will be the sum of the facility's 5.01 resident care rate multiplied by 0.25 and the facility's 5.12 resident care rate multiplied by 0.75.

(B) For the remaining three quarters of each rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30) the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate in accordance with § 1187.96(a)(5) (relating to price and rate setting computations). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the facility's prior quarter 5.01 resident care rate by the percentage change between the facility's current quarter 5.12 resident care rate and the facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the facility's current quarter 5.12 resident care rate by the facility's previous quarter 5.12 resident care rate.

(III) For the remaining three quarters of rate year 2011-2012 (October 1 through December 31; January 1 through March 31; April 1 through June 30) each nursing facility's blended resident care rate will be the sum of the facility's quarterly adjust 5.01 resident care rate multiplied by 0.50 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.50.

(IV) For the remaining three quarters of rate year 2012-2013 (October 1 through December 31; January 1 through March 31; April 1 through June 30) each nursing facility's blended resident care rate will be the sum of the facility's quarterly adjusted 5.01 resident care rate multiplied by 0.25 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.75.

Beginning July 1, 2010, the Statewide average CMI assigned to a new nursing facility will be calculated using the RUG-III version 5.12 44 group values and the most recent classifiable assessment of any type. When a new nursing facility has submitted assessment data that is used in a rate determination the CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI. computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident wilt be the most recent classifiable assessment of any type.

Beginning with rate year 2013-2014, and thereafter, the Department will calculate each nursing facility's resident care rate in accordance with § 1187 .96(a)(1)-(5) (relating to price and rate setting computations). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

b. Other Resident Related

To calculate the other resident related cost medians and prices, the Department divides the audited allowable other resident related costs for each cost report for each nursing facility by the nursing facility's total audited. actual resident days for each cost report year to obtain each nursing facility's other resident related cost per diem for each cost report year.

For year two of implementation, the Department calculates the two year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

The Department arrays the average other resident related cost per diem for each nursing facility within the respective peer groups and determines a median for each peer group. The Department multiplies each median by a factor of 1.12 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010- 2011 and 2011-2012, the median used to set the other resident related price for each peer group will be the phase-out median as determined in accordance with and paragraph d. below.

The Department calculates each nursing facility's facility-specific other resident related rate by taking the lower of the nursing facility's resident related peer group price or 103% of the nursing facility's resident related cost per diem plus 30% of the difference between the 103% calculation, and the nursing facility peer group price.

c. Administrative

The allowable administrative costs are determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs. To calculate the administrative cost medians and prices, the Department adjusts, as appropriate, the total audited actual resident days for each nursing facility to a minimum 90%.

occupancy. The Department then divides the audited allowable administrative costs for each cost report for each nursing facility by the total audited actual resident days, adjusted to 90% occupancy, if applicable, for each cost report year to obtain each nursing facility's administrative cost per diem for the cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

The Department arrays the average administrative cost per diem for each nursing facility within the respective peer groups to determine a median for each peer group. The Department multiplies each median by a factor of 1.04 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

For rate years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012, the median used to set the administrative price for each peer group will be the phase-out median as determined in accordance with paragraph d. below.

A nursing facility's administrative rate equals its administrative peer group price.

d. Phase-Out Median Determination

(1) Beginning with rate year 2006-2007, and thereafter, county MA nursing facilities will not be reimbursed under the case-mix payment system. However, for rate years 2006-2007, 2007-2008 and 2008-2009, county MA nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv) (relating to peer group for price-setting) and the audited county nursing facilities' net operating costs allowable under Chapter 1187, from the three most recent audited cost reports will be included in the established peer groups when determining a median in accordance with § 1187.96 (relating to price and rate setting computations).

(2) For rate years 2009-2010, 2010-2011 and 2011-2012, the Department will determine a phase-out median for each net operating cost center for each peer group to calculate a peer group price. The Department will establish the phase-out median as follows:

(a) The Department will establish an interim phase out median for the rate year as follows:

(i) County nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv) (relating to peer grouping for price setting).

(ii) The audited county nursing facilities' net operating costs allowable under Chapter 1187, from the three most recent audited cost reports will be included in the established peer groups when determining a median in accordance with § 1187.96 (relating to price and rate setting computations).

(b) The phase-out median for 2009-2010 rate year will equal 75% of the interim median calculated in accordance with (a) above plus 25% of the median calculated in accordance with § 1187.96.

(c) The phase-out median for 2010-2011 rate year will equal 50% of the interim median calculated in accordance with (a) above plus 50% of the median calculated in accordance with § 1187.96.

(d) The phase-out median for 2011-2012 rate year will equal 25% of the interim median calculated in accordance with (a) above plus 75% of the median calculated in accordance with § 1187.96.

(3) For rate year 2012-2013 and thereafter, county nursing facilities' allowable MA costs will not be used in the rate-setting process for non-public nursing facilities.

e. Net Operating Rate

The Department determines each nursing facility's per diem net operating rate by adding the nursing facility's case-mix adjusted resident care rate, its other resident related rate and its administrative rate.

4. Capital Rate Setting

The facility-specific capital rate consists of three components: the fixed property component, the movable property component, and the real estate tax component.

(a) Fixed Property Component

The nursing facility's fixed property component is based on the nursing facility's allowable beds, as defined in § 1187.2 (relating to definitions), multiplied by an assigned cost of $26,000 and the associated financial yield rate.

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(b) Movable Property Component

The Department bases the amount of the movable property component on the audited actual acquisition costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database.

(c) Real Estate Tax Cost Component

The Department determines the real estate tax cost component of each nursing facility's capital rate based on the audited actual real estate tax cost, as set forth on the most recent audited MA-11 cost report available in the NIS database.

(d) Capital Rates

The Department adds the nursing facility's fixed property component, movable property component and real estate tax component and divides the sum of the three components by the nursing facility's total actual resident days, adjusted to 90% occupancy, if applicable.

The Department makes capital component payments for fixed property for nursing facility beds constructed, licensed or certified after November 29, 1997, if the Department approves those beds as replacement beds in accordance with Chapter 1187, § 1187.113a(c)-(e).

The Department grants waivers of § 1187.113(a) to permit capital cost reimbursement for fixed property as the Department in its sale discretion determines necessary and appropriate. The criteria the Department uses to evaluate and approve applications for capital cost reimbursement waivers are contained in § 1187.113(b). Waivers of the moratorium regulations granted to nursing facilities under 55 Pa. Code Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulations set forth at 55 Pa. Code § 1187.113(a). Waivers of §1187.113(a) will not otherwise be granted except as provided under § 1187.113(b).

5. Case-Mix Per Diem Rate

(a) A nursing facility's case-mix per diem rate for an MA resident day is the sum of the nursing facility's net operating rate and its capital rate. The Department calculates payment rates on a quarterly basis. Rates are set for nursing facilities with a change of ownership, new nursing facilities and reorganized nursing facilities as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations.

(b) For the rate setting year that began on July 1,2005 and will end on June 30, 2006, a nursing facility's case-mix per diem rate for an MA resident day is the sum of the nursing facility's three net operating rates and its capital rate, multiplied by an adjustment factor of .95122. The nursing facility's payment rate is recalculated on a quarterly basis. Rates for new nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and farmer prospective payment nursing facilities) of the state regulations, and the sum of the net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor of .95122.

(c) For the rate setting year that began on July 1, 2006 and will end on June 30, 2007, a nursing facility's case-mix per diem rate for an MA resident day is the sum of the nursing facility's three net operating components and its capital rate component, multiplied by a budget adjustment factor of .93755. The formula for this budget adjustment factor is as follows: (the total appropriated funds allocated to non-public nursing facility plus the estimated annual patient day) divided by the estimated acuity adjusted annual payments of $3,048,667,339 which equals .93755. The nursing facility's payment rate is recalculated on a quarterly basis. Rates for new nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor of .93755.

(d) for rate setting year 2007-2008, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor for rate setting year 2007-2008 shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities over the three year period commencing July 1, 2005, and ending June 30, 2008, from the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities in rate year 2004-2005 to 9.05%. The formula for this budget adjustment factor as it applies to non-public nursing facilities is as follows: (the non-public nursing facilities' share of total appropriated funds plus the estimated annual patient pay amount) divided by the estimated acuity-adjusted annual payments of $3,147,221,981 which equals .93789.

(i) A non-public nursing facility's case-mix per diem rate for an MA resident day will be the sum of the nursing facility's three net operating components and its capital rate component, multiplied by the budget adjustment factor. The non-public nursing facility's payment rate is recalculated on a quarterly basis.

(ii) Rates for new non-public nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set 1 as specified in § 1187.97 (relating to. rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied I by the same adjustment factor.

(dd) For rate setting year 2008-2009, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor for rate year 2008-2009 shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the aggregate percentage rate of increase for the period that begins July 1, 2005 and ends on June 30, 2009 is limited to the amount permitted by the funds appropriated by the General Appropriations Act of 2008. For the rate setting year beginning July 1, 2008, and ending June 30, 2009 the budget adjustment factor for non-public nursing facilities is equal to .90891.

(i) A non-public nursing facility's case-mix per diem rate for an MA resident day will be the sum of the nursing facility's three net operating components and its capital rate component, multiplied by the budget adjustment factor.' The non-public nursing facility's payment rate is recalculated on a quarterly basis.

(ii) Rates for new non-public nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set as specified in § 1187~97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor.

(ee) For rate setting year 2009-2010, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor for rate year 2009-2010 shall limit the estimated aggregate change in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the aggregate percentage rate of increase for the period that begins July 1, 2009 and ends on June 30, 2010 is limited to the amount permitted by the funds appropriated by the General Appropriations Act of 2009. For the rate setting year 2009-2010, the base budget adjustment factor for non-public nursing facilities is equal to .90275. This base budget adjustment factor may be adjusted for the April- June 2010 calendar quarter and an April BAF computed and applied to nursing facility payment rates for that quarter as specified in Supplement III.

(i) A non-public nursing facility's case-mix per diem rate for an MA resident day will be the sum of the nursing facility's three net operating components and its capital rate component, multiplied by the budget adjustment factor. The non-public nursing facility's payment rate is recalculated on a quarterly basis.

(ii) Rates for new non-public nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set

as specified In § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor.

(ff) For rate setting year 2010-2011, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor for rate setting year 2010-2011 shall limit the estimated aggregate change in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing , facilities so that the aggregate percentage rate of increase for the period that begins July 1, 2010 and ends on June 30, 2011 is limited to the amount permitted by the funds appropriated by the General Appropriations Act of 2010. For the rate setting year 2010- 2011, the base budget adjustment factor for non-public nursing facilities will be calculated as specified in Supplement III. The base budget adjustment factor for the rate setting year may be adjusted for the April - June 2011 calendar quarter and an April BAF computed and applied to nursing facility payment rates for that quarter as specified in Supplement III.

(i) A non-public nursing facility's case-mix per diem rate for an MA resident day will be the sum of the nursing facility’s three net operating components and its capital rate component, multiplied by the budget adjustment factor. The non-public nursing facility's payment rate is recalculated 'on a quarterly basis.

(ii) Rates for new non-public nursing facilities, reorganized facilities and I nursing facilities that experience a change of ownership during the rate year are set as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor.

(gg) For rate setting years 2011-2012, 2012-2013 through 2015-2016, 2016-2017 through 2018-2019, 2019-2020 through 2021-2022, and 2022-2023 through 2025-2026, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor shall limit payment rates for medical assistance nursing facility services for county and non-public nursing facilities so that the statewide day-weighted average payment rate is limited to the amount permitted by the funds appropriated by the General Appropriations Acts. For the rate setting year 2011-2012, the quarterly budget adjustment factor for non-public nursing facilities will be calculated as specified in Supplement III. For rate setting years 2012-2013 through 2015-2016, and 2016-2017 the base budget adjustment factor for non-public nursing facilities will be calculated as specified in Supplement III. The base budget adjustment factor for rate setting years 2012-2013 through 2015-2016, and 2016-2017 may be adjusted for the April - June calendar quarter and an April BAF computed and applied to nursing facility payment rates for that quarter as specified in Supplement III. For the rate setting years 2017-2018 through 2025-2026 the quarterly budget adjustment factor for non-public nursing facilities will be calculated as specified in Supplement III.

(i) A non-public nursing facility's case-mix per diem rate for an MA resident day will be the sum of the nursing facility's three net operating components and its capital rate component, multiplied by the budget adjustment factor. The non-public nursing facility's payment rate is recalculated on a quarterly basis.

(ii) Rates for new non-public nursing facilities, reorganized facilities and nursing facilities that experience a change of ownership during the rate year are set as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations, and the sum of the three net operating and capital rate components for any of these facilities, is then multiplied by the same adjustment factor.

Nonpublic Nursing Facility Case-Mix Rates for Fiscal Year 2023-2024

For fiscal year (FY) 2023-2024, the Department of Human Services shall calculate each nursing facility's case-mix rate based on the cost database and peer group prices for each net operating cost center used in the calculation of each nursing facility's case-mix rates for FY 2022-2023. Each nursing facility's case-mix rate shall be adjusted quarterly in accordance with 55 Pa. Code § 1187.96(a)(5) (relating to price- and rate- setting computations).

(e) In accordance with § 1187.97, if a county nursing facility becomes a nursing facility between July 1, 2006 and June 30, 2012, the per diem rate for the nursing facility will be computed in accordance with § 1187.96, using the data contained in the NIS database. If a county nursing facility becomes a nursing facility November 1, 2012 and thereafter, the per diem rate for the nursing facility will be computed in accordance with § 1187.96, using the peer group price for resident care, other resident related and administrative costs from the appropriate peer group until there is at least one nursing facility cost report submitted from the new provider in the NIS database audited for use in the rebasing process. The fixed property component will be the only component of the capital portion of the per diem rate until there is a least one nursing facility cost report submitted from the new provider in the NIS database audited for use in the rebasing process, and will be computed in accordance with § 1187.96(d)(1).

C. Cost Finding

All nursing facilities participating in the Medical Assistance Program shall use the direct allocation method of cost finding. Under this method of cost finding, costs are apportioned directly to the nursing facility and residential or other facility based on the appropriate financial and statistical data.

D. Cost Reporting and Audit Requirements

All nursing facilities participating in the MA Program shall report allowable costs and the results of the cost finding process on forms specified by the Department. Allowable costs are classified in four cost centers: resident care; other resident related; administrative and capital. Net operating costs include resident care, other resident related and administrative. All records are subject to verification and audit. The financial and statistical records of all nursing facilities are audited periodically by the Department.

A nursing facility shall hold, safeguard and account for residents' personal funds upon written authorization from the resident in accordance with all applicable provisions of state and federal law. The Department periodically audits residents' personal fund account.

E. Allowable Program Costs and Policies

Allowable costs are those which are necessary and reasonable for an efficiently and economically operated nursing facility to provide services to MA residents. Allowable costs are identified in and subject to limitations specified in Subchapter E (relating to Allowable Program Costs and Policies), Subchapter H (relating to Payment conditions, Limitations and Adjustments) of 55 Pa. Code Chapter 1187, including the related party cost and prudent buyer principles set forth in Sections 1187.57 and 1187.60. Only the direct and indirect costs related to resident care are allowable. Any costs of materials or services covered by payments made directly to providers, other than nursing facility services under Medicaid and Medicare or other insurers and third parties, are not allowable.

All nursing facilities participating in the MA Program must allocate costs between nursing facility services and non-nursing facility services in accordance with the allocation bases established or approved by the Department.

The assessment applied to nursing facilities for fiscal years (FYs) 2003-2004 through 2006-2007, and 2007-2008 through 2011-2012, and 20012-2013 through 2015-2016 is an allowable cost under the Medical Assistance Program. The Medical Assistance portion of this assessment cost will be reimbursed as an add-on to a nursing facility's per diem rate and will be paid in lump sum on a quarterly basis. The Department will determine the nursing facility's MA allowable assessment cost by dividing the facility's Quarterly Assessment Payment by the Facility's total resident days in the applicable corresponding assessment quarter and then multiplying the result by the facility's MA days in the applicable corresponding quarter.

The assessment applied to nursing facilities beginning FY 2016-2017 is an allowable cost under the Medical Assistance Program. The Medical Assistance portion of this assessment cost will be reimbursed as an add-on to a nursing facility's per diem rate and will be paid in a lump sum on a quarterly basis. A facility will not receive this add-on if they are located in a geographic zone where Community HealthChoices operates during the entire assessment quarter for which the reimbursement is being made. The Department will determine the nursing facility's MA allowable assessment cost per diem by dividing the facility's Quarterly Installment Assessment Payment by the facility's total resident days in the applicable corresponding period used to calculate the annual assessment payment and then multiplying the result by the facility's MA days in the corresponding period used to calculate the annual assessment payment.

EE. Payment for Costs Incurred by County Nursing Facilities

For public nursing home care provided during fiscal year 20O5-2006 (July 1, 2005 - June 30, 2006), the Department will recognize the costs incurred by county nursing facilities to provide services to eligible persons as Medical Assistance Program expenditures to the extent the costs qualify for Federal matching funds and so long as the costs are: (i) reasonable and allowable as determined by the Department in accordance with the payment methodology in attachment 4.19D; and (ii) reported and certified to have been incurred by the county nursing facilities for the provision of Medicaid services in a form and manner specified by the Department

The Department will make regular program payments to county nursing facilities based on the rate setting methodology contained in 55 Pa. Code Chapter 1187. In addition, costs incurred by county nursing facilities that exceed regular program payments will be recognized as allowable Medicaid costs. These additional allowable costs will be recognized at the end of each quarter during which they occur. The Department will estimate these additional costs for the rate year using the costs certified by the county nursing facilities from their most recent audited cost reports. These costs will be trended forward to FY 2005-2006 using the most currently available CMS Nursing Home without Capital Market Basket Index, total index level. The final payment amount authorized under this provision will be determined by reconciling estimated costs in excess of the regular program payments as provided above plus the regular program payments to the audited Medicaid costs for Medicaid services for the rate year.

The Department of Health's annual health-~are associated infection (HAI) surcharge on a nursing facility's licensing fee is an allowable cost under the MA Program. The MA portion of the HAI surcharge will be reimbursed as a pass-through payment and will be paid on an annual basis. A nursing facility's annual HAI pass-through payment will equal the annual HAI surcharge fee paid by the nursing facility, less any penalties assessed, as verified by the DOH, multiplied by the nursing facility's MA occupancy rate as reported on the nursing facility's cost report for the fiscal year in which the annual HAI surcharge is paid. The HAI pass-through payment will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before the later of 210 days from the close of the nursing facility fiscal year or the date on which the DOH received payment of the nursing facility's HAI surcharge fee

F. Hospice Services

If an MA recipient residing in a nursing facility is dually eligible for Medicare Part A services and elects to receive hospice services in lieu of nursing facility services, as applicable, the MA Program pays a Medicare-certified hospice provider an amount equal to the room and board payment made to the nursing facility as part of the nursing facility services and will discontinue direct payment to the nursing facility for services. The hospice provider, in order to receive payment from the Department, shall enter into an agreement with the nursing facility by which the hospice provider agrees to assume full responsibility for the recipient's hospice care and the nursing facility agrees to provide room and board to the recipient. (See Attachment 4.198, Item #21).

G. Transition Rates

1. County Nursing Facilities

a. For the period January 1, 1996 through June 30, 1996, each county owned and operated nursing facility, as defined in § 1187.2 (relating to definitions) of the state regulations, receiving a county nursing facility rate as of June 30, 1995, will be provided with a transition rate. The transition rate for each county nursing facility for January 1, 1996 through June 30, 1996, will be the higher of the case-mix rate for each respective quarter or a December 31, 1995 facility blended rate. The blended rate is calculated by multiplying the skilled/heavy care rate on file as of December 31, 1995 by the number of skilled/heavy care days as reported in the county nursing facility's most recently accepted cost report; multiplying the intermediate care rate on file as of December 31, 1995 by the number of intermediate care days reported in the county nursing facility's most recently accepted cost report; summing these products and dividing that sum by the number of skilled care, heavy care and intermediate care days as reported in the county nursing facility's most recently accepted cost report. The blended rate will be trended forward three months from January 1, 1996 to March 31, 1996 by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the second quarter 1995 issue of the DRI McGraw-Hill publication "Health Care Costs."

b. For the period July 1, 1996 through June 30, 1997, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or a facility blended rate calculated in the manner indicated in G.1 .a. above, trended forward nine months from April 1, 1996 to December 31, 1996 by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1995 issue of the DRI McGraw-Hill publication "Health Care Costs".

c. For the period July 1, 1997 through June 30, 1998, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.b. above, trended forward twelve months from January 1, 1997 to December 31, 1997 by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1996 issue of the DRI McGraw-Hill publication "Health Care Costs."

d. For the period July 1, 1998 through December 31, 1998, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified

in G.1.c. above, trended forward nine months from January 1, 1998 to September 30, 1998 by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1997 issue of the DRI McGraw-Hill publication "Health Care Costs."

e. For the period January 1, 1999 through June 30, 1999, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.d. above, trended forward six months from January 1, 1999 to June 30, 1999 by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1998 issue of the DRI McGraw-Hill publication "Health Care Costs."

f. For the period July 1, 1999 through June 30, 2000, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.e. above, trended forward nine months by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1998 issue of the DRI McGraw-Hill publication "HealthCare Costs."

g. For the period July 1, 2000 through June 30, 2001, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.f above, trended forward twelve months by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 1999 issue of the DRI McGraw-Hill publication "Health Care Costs."

h. For the period July 1, 2001 through June 30, 2002, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.g. above, trended forward twelve months by a factor equal to the HCFA Nursing Home' without Capital Market Basket Index as published in the fourth quarter 2000 issue of the DRI McGraw-Hill publication "Health Care Costs."

i. For the period July 1, 2002 through June 30, 2003, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.h. above, trended forward twelve months by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 2001 issue of the DRI McGraw-Hill publication "Health Care Costs."

j. For the period July 1 , 2003 through June 30, 2004, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter or the facility transition rate identified in G.1.i. above, trended forward 15 months from October 2002 to December 2003, by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 2002 issue of the Global Insight publication "Health Care Cost Review."

k. For the period July 1, 2004 through June 30, 2005, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter the facility transition rate identified in G.1.j. above, trended fonv-a1d twelve months from January 2004 to December 2004, by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quarter 2003 issue of the Global Insight publication "Health Care Cost Review."

l. For the period July 1, 2005 through June 30, 2006, transition rates for county nursing facilities will be the higher of the case-mix rate for each respective quarter of the facility transition rate identified in G.1.k. above, trended forward twelve months from January 2005 to December 2005, by a factor equal to the HCFA Nursing Home without Capital Market Basket Index as published in the fourth quafreieOO4 issue of the Global Insight publication "Health Care Cost Review."

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2. General Nursing Facilities

a. For the period of January1, 1996, through June 30, 1996, general nursing facilities other than hospital-based, special rehabilitation and county nursing facilities, will be provided a transition rate. The transition rate for each general nursing facility for each calendar quarter, during the time period January 1, 1996 through June 30, 1996 will be the higher of the facility case-mix rate for that quarter or a July 1, 1994 facility blended rate. The facility blended rate is a composite of the skilled care and intermediate care interim per diem rates in effect on July 1, 1994 weighted by the reported MA days associated with the respective acuity levels.

b. Enhanced Transition Payments.

(i) For the period July 1, 1996 through June 30, 1997, an enhanced transition payment (ETP), calculated in accordance with (iii) below, will be made to qualifying general nursing facilities, as defined in (ii) below, that agree in writing to accept the conditions specified in (v) below.

(ii) To qualify for an ETP, a nursing facility must meet all of the following requirements:

(A) As of July 1, 1996, the nursing facility must meet the definition of a general nursing facility, a hospital-based nursing facility, or a special rehabilitation facility as defined at 55 Pa. Code 3 1187.2. County nursing facilities, as defined at 55 Pa. Code 3 1187.2, are not eligible for ETPs.

(B) The nursing facility must have an MA-11 cost report covering a twelve-month period filed with and accepted by the Department as of March 31, 1996.

(C) The nursing facility must have an "alternate per diem rate" calculated in accordance with (iv) below that is greater than either its January 1, 1996 or its July 1, 1996 case-mix per diem rate, or both.

(iii) The ETP for each qualifying general nursing facility is determined as follows:

(A) An amount is determined by subtracting the January 1, 1996 case-mix per diem rate for each qualifying nursing facility from its alternate per diem rate as determined under b(iv) below. If the difference is greater than zero, the difference is multiplied by one-half of the annual number of Medical Assistance days of nursing facility care as reported on the nursing facility's most recently accepted unaudited MA-11 cost report on file with the Department as of March 31, 1996, to establish the nursing facility's gross differential for the period January to June 1996. If the difference is zero or less, the differential for that nursing facility is set at zero.

(B) An amount is determined by subtracting the July 1, 1996, case-mix per diem rate for each qualifying nursing facility from its alternate per diem rate as determined under b(iv) below. If the difference is greater than zero, the difference is multiplied by the annual number of Medical Assistance days of nursing facility care as reported on the nursing facility's most recently accepted unaudited MA-11 cost report on file with the Department as of March 31, 1996, to establish the nursing facility's gross differential for the period July 1996, to June 1997. If the difference is zero or less, the differential for that nursing facility is set at zero.

(C) The January to June, 1996 differential from (A) is added to the July to June, 1997 differential from (8) to establish the total gross differential for each eligible nursing facility.

(D) The total gross differential established in (C) is multiplied by a factor to establish the enhanced transition payment amount for each eligible nursing facility. The factor is determined by dividing $71,739,000 by the sum of the gross differential amounts for all eligible nursing facilities as calculated under (C).

(E) The enhanced transition payment for a qualifying nursing facility as determined according to the method provided in (iii) will be reduced by any additional reimbursement that may have been authorized for that nursing facility as a result of the successful appeal or amicable settlement of a case-mix related issue.

(iv) For purposes of calculating the enhanced transition payment, an "alternate per diem rate" is determined for each nursing facility using the rate setting provisions of 55 Pa. Code Chapter 1187 applied as if the rate were to be effective July 1, 1996, but with the following exceptions:

(A) The cost report database used in establishing the net operating portions of the alternate per diem rates will be the single most current MA-11 cost report covering a twelve-month period for each nursing facility which was filed with an accepted by the Department on or before March 31, 1996.

(B) The inflation factor used in calculating the alternate per diem rate is the HCFA Nursing Home Without Capital Market Basket Index plus .75% per year.

(C) The provisions of 55 Pa Code Chapter 1187, 1187.33(b)(3) (relating to resident data reporting requirements) do not apply.

(D) The capital component of the alternate per diem rate is the capital component of each nursing facility's July 1, 1996, case-mix per diem rate.

(v) To receive an ETP, a qualifying nursing facility must agree in writing, in a form specified by the Department, to all of the following:

(A) It will withdraw existing appeals of case-mix related issues that had been filed for the period January 1, 1996 through June 30, 1997, except for those appeals set forth in (D) below.

(B) It will waive its right to file appeals relating to any case-mix issues for the period January 1, 1996 through June 30, 1997, except for those appeals set forth in (D) below.

(C) It will provide the Department with a separate accounting of the nursing facility's uses of the ETP payment.

(D) The following appeal rights are preserved and may be pursued by any nursing facility including those qualifying for enhanced transition payments:

(1) Appeals related to data input or mathematical errors made by the Department in setting individual nursing facility payment rates.

(2) Appeals related to the payment system in place prior to January 1, 1996.

(3) Appeals related to 180 day billing issues.

(4) Appeals related to the medical necessity for nursing facility care, and Utilization Management Review Team adverse action is regarding acuity level determinations or case-mix index determinations.

(5) Appeals related to the case-mix capital payment for movable equipment, except those appeals related to the moratorium of new bed construction, which must be withdrawn pursuant to (v)(A) above. If, however, a nursing facility pursues an appeal on movable equipment not related to the moratorium on new bed construction and ultimately prevails in such appeal, any amount awarded through the appeal will be reduced by any enhanced transition payment amount received. If the enhanced transition payment is greater than the amount awarded through such successful appeal, no additional payment will be made by the Commonwealth for the appeal.

6) Appeals related to future changes in regulations that apply to FY 1996-97, whether such changes occur during FY 1996-97 or occur after FY 1996-97, but which retroactively affect that fiscal year.

3. County and General Nursing Facilities

a. An MDS 2.0 transition payment will be made available to county and general nursing facilities, including hospital-based and special rehabilitation nursing facilities for the fiscal period July 1,1998 through June 30, 1999. MDS 2.0 transition payments will be calculated and paid in accordance with paragraphs b through d below.

b. A quarterly base rate will be calculated for each facility for every fiscal quarter. The quarterly base rate will equal the facility's April 1998 case-mix rate inflated by the HCFA Nursing Home without Capital Market Basket Index according to the number of quarters between April 199B and the rate setting quarter.

c. For the fiscal period July 1,1998 through June .30,1999, a facility that submits assessments required to set rates will receive payment as follows:

(i) The facility will receive a payment that is equal to the sum of the following amounts:

(A) The positive difference between the facility’s July 1, 1998 quarterly base rate and its July 1, 1998 quarterly case-mix rate multiplied by the number of Medical Assistance days of care for the quarter that were paid through the Medical Assistance Management Information System (MAMIS) plus one-third of the positive difference between the facility’s quarterly base rate and its quarterly case-mix rate multiplied by the number of Medical Assistance hospital days for the quarter that were paid through MAMIS.

(B) The positive difference between the facility's October 1, 1998 quarterly base rate and its October 1, 1998 quarterly case-mix rate multiplied by the number of Medical Assistance days of care for the quarter that were paid through the MAMIS plus one-third of the positive difference between the facility's quarterly base rate and its quarterly case-mix rate multiplied by the number of Medical Assistance hospital days for the quarter that were paid through MAMIS.

(C) The positive difference between the facility's January 1,1999 quarterly base rate and its January 1,1999 quarterly case-mix rate multiplied by the number of Medical Assistance days of care for the quarter that were paid through the MAMIS plus one-third of the positive difference between the facility's quarterly base rate and its quarterly / case-mix rate multiplied by the number of Medical Assistance hospital days for the quarter that were paid through MAMIS.

(D) The positive difference between the facility's April 1,1999 quarterly base rate and its April 1,1999 quarterly case-mix rare multiplied by the number of Medical Assistance days of care for the quarter that were paid through the MAMIS plus one-third of the positive difference between the facility's base rate and its quarterly case-mix rate multiplied by the number of Medical Assistance hospital days for the quarter that were paid through MAMIS.

d Payment for Medical Assistance days of care and Medical Assistance hospital days remains subject to all applicable billing instructions and payment requirements. The Department will not make MDS 20 transition payments for resident days of care or hospital days that are rejected for payment through MAMIS.

H. Disproportionate Share

1. A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities that are not located in a geographic zone where Community HealthChoices operates at the time the payment should be made as described in (4) below. To qualify for the payment a facility must meet the following criteria for a 12-month facility cost reporting period.

a. The nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

b. The nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

2. The disproportionate share incentive payments will be based on the following for year one of implementation:

	Overall Occupancy	MA Occupancy (y)	Per Diem Incentive
Group A	90%	>90%y	$2.50
Group B	90%	88%<y<90%	$1.70
Group C	90%	86%<y<88%	$1.00
Group D	90%	84%<y<86%	$0.60
Group E	90%	82%<y<84%	$0.30
Group F	90%	80%<y<82%	$0.20

3. For each year subsequent to year one of implementation, disproportionate share incentive payments as described in (2) above Will be inflated forward using the most current available Healthcare Cost Review CMS Nursing Home without Capital Market Basket Index, total index level, to the end point of the rate setting year for which the payments are made.

4. These payments Will be made annually within 120 days after the submission of an acceptable cost report provided that in no case will payment be made before 210 days of the close of the nursing facility fiscal year.

5. For year one of implementation only, facilities with a June 30 cost report year end will receive a disproportionate share payment based on the January 1 through June 30 time period.

6. The disproportionate share incentive payment to qualified nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with 55 Pa. Code 1187.111 (c) as follows:

a. For the period commencing January 1, 2000 through June 30, 2000, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 1999 or June 30, 2000.

b. For the period commencing July 1, 2000 through June 30, 2001, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2000 or June 30, 2001.

c. For the period commencing July 1, 2001 through June 30, 2002, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2001 or June 30, 2002.

d. For the period commencing July 1, 2002 through June 30, 2003, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2002 or June 30, 2003.

e. For the period commencing July 1, 2003 through June 30, 2004, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2003 or June 30, 2004.

f. For the period commencing July 1, 2004 through June 30, 2005, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2004 or June 30, 2005.

g. For the period commencing July 1, 2005 through June 30, 2006, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2005 or June 30, 2006.

h. For the period commencing July 1, 2006 through June 30,2007, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2006 or June 30, 2007.

i. For the period commencing July 1, 2007 through June 30, 2008, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2007 or June 30, 2008.

j. For the period commencing July 1, 2008 through June 30, 2009, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31,2008 or June 30, 2009.

I. Supplementation Payments

1. County Nursing Facilities

a. For state fiscal periods commencing on or after July 1, 1996, and ending prior to July 1, 2005, and subject to the availability of sufficient county, state and federal funds based upon an executed intergovernmental transfer agreement and subsequent transfer of funds, the Department will pay supplementation payments to county nursing facilities in which MA-funded resident days account for at least 80% of the nursing facility's total resident days and the number of certified MA beds is greater than 270 beds.

The Department will use the following methodology to calculate these payments:

(i) The Department will calculate the maximum additional payments that it can make to participating nursing facilities under its state plan in' conformity with 42 CFR 447.272(a).

(ii) The Department will identify eligible county nursing facilities.

(iii) The Department will negotiate a total supplementation payment amount with eligible county nursing facilities. The negotiated total supplementation payment amount may equal but will not exceed the Medicare upper limit amount calculated in a, above.

(iv) The Department will select the latest fiscal period for which all eligible county nursing facilities have an acceptable cost report on file with the Department and will sum the total MA allowable costs reported by the eligible county nursing facilities for that fiscal period.

(v) The Department will divide the total supplementation payment amount by the total MA costs to derive the supplementation percentage.

(vi) The Department will multiply each eligible county nursing facility's reported MA costs for the fiscal period selected in (iv) above by the supplementation percentage to determine that county nursing facility's supplementation payment.

b. For state fiscal years 2005 through 2009 (the transition period), subject to the availability of sufficient county, state and federal funds, the Department will make county supplementation payments to county nursing facilities in which MA days, as defined in 55 Pa. Code § 1187.2, account for at least 80% of the nursing facility's total resident days and the number of certified MA beds in the nursing facility is greater than 270 beds.

The Department will negotiate a total supplementation payment amount with eligible county nursing facilities. The county supplementation payments during the transition period will be based upon an executed intergovernmental transfer agreement and a subsequent transfer of funds. The total supplementation payment amount in each state fiscal year of the transition period will equal the annual amount set forth in Supplement II.

2. Nonpublic Nursing Facilities

The Department will pay quarterly supplemental payments to qualified nursing facilities for state fiscal years July 1, 2003 through June 30, 2007, July 1, 2007 through June 30, 2012, July 1 2012 through June 30, 2016, July 1, 2016 through June 30, 2019, and for the period July 1, 2019 through December 31, 2019.

a. To qualify for a quarterly supplemental payment a nursing facility must:

(i) Meet the definition of a nursing facility as defined in 55 Pa. Code § 1187.2.

(ii) Have participated continuously in the MA Program during the entire corresponding assessment quarter.

(iii) Have reported the information requested by the Department in the manner and time period specified by the Department for the corresponding assessment quarter.

(iv) Be located in a geographic zone where Community HealthChoices does not operate during the entire corresponding assessment quarter.

b. A nursing facility that is no longer participating in the MA Program on the day on which the supplemental payment is being made will still be eligible to receive a supplemental payment so long as, in addition to meeting the criteria in paragraph a. above, the facility has paid the assessment amount due to the Department for the corresponding assessment quarter.

c. A nonpublic nursing facility that undergoes a change in ownership will still be eligible to receive a supplemental payment so long as it meets the criteria in paragraph a above.

d. When a nonpublic nursing facility undergoes a change in ownership, the supplemental payment will be made to the legal entity of the nursing facility on the date the supplemental payment is processed by the Department.

e. For state fiscal year 2003-2004 the Department will determine a qualified nursing facility's supplemental payment by multiplying the facility's MA days as reported by the facility for the corresponding assessment quarter by $10.66.

f-1. For state fiscal years July 1,2004 through June 30, 2007, July 1,2007 through June 30, 2012, and July 1. 2012 through June 30, 2016, a qualified nursing facility's supplemental payment will be determined as follows:

(i) The Department will estimate the amount available for supplemental payments by subtracting from the assessment revenue the amount necessary to maintain nursin9 facility payment rates and the amount necessary to reimburse MA allowable costs related to the assessment.

(ii) The available statewide supplemental revenue will then be divided by the most recent statewide MA days available to determine the supplemental per diem amount.

(iii) The supplemental per diem amount will then be multiplied by the qualified nursing facility's quarterly MA days as reported by the facility for the corresponding assessment quarter. The product of this calculation will be the qualified nursing facility's quarterly supplemental payment.

f-2. For state fiscal years July 1, 2016 through June 30, 2019 a qualified nursing facility's supplemental payment will be determined as follows:

(i) The Department will estimate the amount available for supplemental payments by subtracting from the assessment revenue the amount necessary to maintain nursing facility payment rates, the amount to be used for participating . nursing facility providers in Community HealthChoices and the amount necessary to reimburse MA allowable costs related to the assessment for qualified nursing facilities.

(ii) The available statewide supplemental revenue will then be divided by the facilities' MA days in the corresponding period used to calculate the annual assessment payment for qualified nursing facilities to determine the supplemental per diem amount.

(iii) The supplemental per diem amount will then be multiplied by the qualified nursing facility's MA days in the corresponding period used to calculate the annual assessment payment and divided by 4. The product of this calculation will be the qualified nursing facility's quarterly supplemental payment.

f-3. For the July 1, 2019 through December 31, 2019 the Department will determine a qualified nursing facility's supplemental payment by multiplying the facility's MA days in the corresponding period used to calculate the annual assessment payment by $14.98. The product of this calculation will be divided by 4 to determine the qualified nursing facility's quarterly supplemental payment.

g. The information furnished by each qualified nursing facility is subject to audit verification by the Department.

h. A nursing facility that is aggrieved by a determination of the Department as to the amount of the quarterly supplemental payment due to the nursing facility may file a request for review of the decision with the Bureau of Hearings and Appeals.

3. Supplemental Ventilator Care Payments for Nonpublic Nursing Facilities

(a) The Department will pay a supplemental ventilator care payment each calendar quarter, beginning July 1,2012 through June 30,2014, to nursing facilities subject to the following:

(i) To qualify for the supplemental payment, the facility must first satisfy both of the following threshold criteria on the given Picture Date:

a. the facility must have, at least, ten MA-recipient residents who receive necessary ventilator care; and

b. the facility must have, at least, ten percent (10%) of their MA-recipient resident population receiving necessary ventilator care.

For example, a nursing facility with 120 MA-recipient residents must have at least 12 MA-recipient residents who require necessary ventilator care. Whereas, a facility with only 60 MA-recipient residents must have at least 10 MA-recipients who receive necessary ventilator care.

(ii) For purposes of subsection (a)(i), the percentage of the nursing facility's MA-recipient residents who receive necessary ventilator care will be calculated by dividing the total number of MA-recipient residents who receive necessary ventilator care by the total number of MA-recipient residents, and the result will be rounded to two percentage decimal points.

(iii) To qualify as a MA-recipient resident who receives necessary ventilator care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use on the Federally-approved, PA-specific MDS assessment listed on the nursing facility's CMI Report for the given Picture Date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the nursing facility's CMI Report for the given Picture Date.

(v) The applicable Picture Dates and the schedule for authorization of any associated quarterly supplemental ventilator care payment are as follows:

Picture Date	Supplemental Ventilator Care Payment
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a nursing facility fails to submit a valid CMI Report for the picture date in the time frame outlined in § 1187.33(a)(5) (relating to resident data and picture date reporting requirements), the facility cannot qualify for a supplemental ventilator care payment.

(b) A nursing facility's supplemental ventilator care payment is calculated as follows:

(i) The supplemental ventilator care per diem shall equal((number of MA-recipient residents who receive necessary ventilator care/total MA-recipient residents) x $69) x (the number of MA-recipient residents who receive necessary ventilator care/total MA-recipient residents).

(ii) The amount of total supplemental ventilator care payment shall equal the supplemental ventilator care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(iii) If the Department grants a waiver to the 180-day billing requirement, the MA-paid days that may be billed pursuant to the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care payment, and the Department will not retroactively revise the payment amount.

(iv) The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care payment as described above will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in subsection (a).

(c) These payments will be made quarterly in each month listed in subsection (a).

3a. Supplemental Ventilator Care and Tracheostomy Care Payment for Nonpublic Nursing Facilities

(a) The Department will pay a supplemental ventilator care and tracheostomy care payment each calendar quarter, beginning July 1, 2014, to nursing facilities and effective January 1, 2018, to nursing facilities that are not located in a geographic zone where Community HealthChoices operates subject to the following:

(i) To qualify for the supplemental payment, the facility must first satisfy both of the following threshold criteria on the given Picture Date:

a. the facility must have, at least, ten MA-recipient residents who receive necessary ventilator care or tracheostomy care; and

b. the facility must have, at least, ten percent (10%) of their MA-recipient resident population receiving necessary ventilator care or tracheostomy care.

For example, a nursing facility with 120 MA-recipient residents must have at least 12 MA-recipient residents who require necessary ventilator care or . tracheostomy care. Whereas, a facility with only 60 MA-recipient residents must have at least 10 MA-recipients who receive necessary ventilator care or tracheostomy care.

(ii) For purposes of subsection (a)(i), the percentage of the nursing facility's MA-recipient residents who receive necessary ventilator care or tracheostomy care will be calculated by dividing the total number of MA-recipient residents who receive necessary ventilator care or tracheostomy care by the total number of MA-recipient residents as described in subparagraph (iv), and the result will be rounded to two percentage decimal points, (For example, .0945 will be rounded to .09 (or 9%); .1262 will be rounded to .13 (or 13)).

(iii) To qualify as a MA-recipient resident who receives necessary ventilator care or tracheostomy care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use or tracheostomy care on the Federally-approved, PA-specific MDS assessment listed on the nursing facility's CMI Report for the given Picture Date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the nursing facility's CMI Report for the given Picture Date. MA-pending individuals or those individuals found to be MA eligible after the nursing facility submits a valid CMI report for the picture date as provided under § 1187.33{a)(5) (relating to resident data and picture date reporting requirements) shall not be included in the count and shall not result in an adjustment of the percent of ventilator dependent or tracheostomy care MA residents.

(v) The applicable Picture Dates and the schedule for authorization of any associated quarterly supplemental ventilator care and tracheostomy care payment are as follows:

Picture Date	Supplemental Ventilator Care and Tracheostomy Care Payment
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a nursing facility fails to submit a valid CMI Report for the picture date in the time frame outlined in § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care and tracheostomy care payment.

(b) A nursing facility's supplemental ventilator care and tracheostomy care payment is calculated as follows:

(i) The supplemental ventilator care and tracheostomy care per diem shall equal ((number of MA-recipient residents who receive necessary ventilator care or tracheostomy care/total MA-recipient residents) x $69) x (the number of MA-recipient residents who receive necessary ventilator care or tracheostomy care/total MA-recipient residents).

(ii) The amount of total supplemental ventilator care and tracheostomy care payment shall equal the supplemental ventilator care and tracheostomy care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(iii) If the Department grants a waiver to the 180-day billing requirement, the MA-paid days that may be billed pursuant to the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care and tracheostomy care payment, and the Department will not retroactively revise the payment amount.

(iv) The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care and tracheostomy care payment as described above will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in subsection (a).

(c) These payments will be made quarterly in each month listed in subsection (a).

4. MA Day One Incentive Payments for Nonpublic Nursing Facilities

(a) MA Day One Incentive payment for FY 2013-2014 and 2014-2015. The Department will make MA Day One Incentive (MODI) payments to each qualified nursing facility as an incentive to increase access care for the poor and indigent citizens of Pennsylvania.

(i) An MDOI payment for each qualified nursing facility will be calculated and paid on a quarterly basis.

(ii) To qualify for a quarterly MOOI payment, the facility must:

a. Have reported the resident day information to the Department for the applicable Day Quarter in the manner specified by the Department in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual by the applicable date in subsection (b).

b. Meet the definition of a nursing facility as defined in 55 Pa. Code § 1187.2 for the entire applicable Resident Day Quarter.

c. Have an overall occupancy rate of at least 85% during the applicable Resident Day Quarter.

d. Have a MA occupancy rate of at least 65% during the applicable Resident Day Quarter.

(iii) For purposes of subsection (a)(ii) above, Overall occupancy rate = (Total Resident Days divided by (licensed bed capacity at the end of the quarter x the number of calendar days in the quarter)). MA occupancy rate = Total PA MA days divided by Total Resident Days.

(iv) The Department will use the Total PA MA days and the Total Resident Days defined in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual as reported by nursing facilities on the applicable nursing facility assessment resident day reporting forms to determine eligibility and calculate payments.

(b) The Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31 for the April 1-June 30 Resident Day Quarter, January 31 for the July 1-September 30 Resident Day Quarter, April 30 for the October 1-December 31 Resident Day Quarter and July 31 for the January 1-March 31 Resident Day Quarter to calculate each qualified nursing facility's MDOI quarterly payment based on the following formula:

(i) The MODI quarterly per diem will be 1/4 of the total funds appropriated for the fiscal year divided by the Total PA MA days as reported by all qualifying nursing facilities for the applicable Resident Day Quarter.

(ii) The quarterly MDOI per diem will then be multiplied by each qualified nursing facility's Total PA MA days, as reported, for the applicable Resident Day Quarter to determine its quarterly MDOI payment.

(iii) The Department will not retroactively revise a MDOI payment amount based on a nursing facility's late submission or revision of its nursing facility assessment quarterly resident day report related to the dates above. The Department may recoup payments based on an audit of a nursing facility's report.

(iv) The state funds allocated for FY 2013-2014 and 2014-2015 are as follows:

FY - 2013-2014 - $8,000,000
FY - 2014-2015 - $8,000,000

5. MA Day One incentive Payments for Nonpublic Nursing Facilities

(a) MA Day One Incentive payment for FYs 2015-2016 and 2016-2017. The Department will make MA Day One Incentive (MDOI) payments to each qualified nursing facility as an incentive to increase access to care for the poor and indigent citizens of Pennsylvania.

(i) Each nursing facility may qualify for a maximum of four MDOI payments. MDOI payments for each qualified-nursing facility will be based on data from the nursing facility assessment quarterly resident day reporting forms and calculated as described in subsection (b).

(ii) To qualify for a MDOI payment, the facility must:

a. Have reported the resident day information to the Department for the applicable Resident Day Quarter in the manner specified by the Department in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual by the applicable date in subsection (b).

b. Meet the definition of a nursing facility as defined in 55 Pa. Code § 1187.2 for the entire applicable Resident Day Quarter.

c. Have an overall occupancy rate of at least 85% during the applicable Resident Day Quarter.

d. Have a MA occupancy rate of at least 65% during the applicable Resident Day Quarter.

(iii) For purposes of subsection (a)(ii) above, Overall occupancy rate = (Total Resident Days divided by (licensed bed capacity at the end of the quarter x the number of calendar days in the quarter)). MA occupancy rate = Total PA MA days divided by Total Resident Days.

(iv) The Department will use the Total PA MA days and the Total Resident Days defined in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual as reported by nursing facilities on the applicable nursing facility assessment resident day reporting forms to determine eligibility and calculate payments.

(b) The Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31 for the April t-June 30 Resident Day Quarter to calculate the first MODI payment, January 31 for the July 1-September 30 Resident Day Quarter to calculate the second MDOI payment, April 30 for the October 1-December 31 Resident Day Quarter to calculate the third MDOI payment and July 31 for the January 1-March 31 Resident Day Quarter to calculate the fourth MDOI payment for each qualified nursing facility based on the following formula:

(i) A MDOI per diem for each of the four MDOI payments will be ¼ of the total funds appropriated for the fiscal year divided by the Total PA MA days as reported by all qualifying nursing facilities for the applicable Resident Day Quarter.

(ii) Each MDOI per diem will then be multiplied by each qualified nursing facility's Total PA MA days, as reported, for the applicable Resident Day Quarter to determine its MDOI payment.

(iii) The Department will not retroactively revise a MDOI payment amount based on a nursing facility's late submission or revision of its nursing facility assessment quarterly resident day report related to the dates above. The Department may recoup payments based on an audit of a nursing facility's report.

(iv) The state funds allocated for FYs 2015-2016 and 2016-2017 is as follows:

FY - 2015-2016 - $8,000,000
FY - 2016-2017 - $8,000,000

5a. MA Day One Incentive Payments for Nonpublic Nursing Facilities

(a) MA Day One Incentive payment for FY 2017-2018. The Department will make MA Day One Incentive (MDOI) payments to each qualified nursing facility as an incentive to Increase access to care for the poor and indigent citizens of Pennsylvania.

(i) Each nursing facility may qualify for a maximum of two MOOI payments. MDOI payments for each qualified nursing facility will be based on data from the nursing facility assessment quarterly resident day reporting forms and calculated as described in subsection (b).

(ii) To qualify for a MODI payment, the facility must:

a. Have reported the resident day information to the Department for the applicable Resident Day Quarter in the manner specified by the Department in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual by the applicable date in subsection (b).

b. Meet the definition of a nursing facility as defined in 55 Pa. Code § 1187.2 for the entire applicable Resident Day Quarter.

c. Have an overall occupancy rate of at least 85% during the applicable Resident Day Quarter.

d. Have a MA occupancy rate of at least 65% during the applicable Resident Day Quarter.

(iii) For purposes of subsection (a)(ii) above, Overall occupancy rate = (Total Resident Days divided by (licensed bed capacity at the end of the quarter x the number of calendar days in the quarter)). MA occupancy rate = Total PA MA days divided by Total Resident Days.

(iv) The Department will use the Total PA MA days and the Total Resident Days defined in the PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual as reported by nursing facilities on the applicable nursing facility assessment resident day reporting forms to determine eligibility and calculate payments.

(b) The Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31 for the April1-June 30 Resident Day Quarter to calculate the first MDOI payment and January 31 for the July 1-September 30 Resident Day Quarter to calculate the second MDOI payment for each qualified nursing facility based on the following formula:

(i) A MDOI per diem for each of the two MDOI payments will be 1/2 of the total funds appropriated for the fiscal year divided by the Total PA MA days as reported by all qualifying nursing facilities for the applicable Resident Day Quarter.

(ii) Each MDOI per diem will then be multiplied by each qualified nursing facility's Total PA MA days, as reported, for the applicable Resident Day Quarter to determine Its MDOI payment.

(iii) The Department will not retroactively revise a MDOI payment amount based on a nursing facility's late submission or revision of its nursing facility assessment quarterly resident day report related to the dates above. The Department may recoup payments based on an audit of a nursing facility's report.

(iv) The state funds allocated for FY 2017-2018 is $8,000.000.

5b. *MA Day One Incentive Payments for Nonpublic Nursing Facilities*

(a) MA Day One Incentive payment for FYs 2018-2019, 2019-2020, 2020-2021, 2021- 2022, 2022-2023, 2023-2024 and 2024-2025. The Department will make MA Day One Incentive (MDOI) payments to each qualified nursing facility as an incentive to increase access to care for the poor and indigent citizens of Pennsylvania.

(i) Each nursing facility may qualify for a maximum of two MDOI payments. MDOI payments for each qualified nursing facility will be based on data from the nursing facility assessment quarterly resident day reporting forms and calculated as described in the following subsections.

(ii) To qualify for a MDOI payment, the facility must:

a. Have reported the resident day information to the Department for the applicable Resident Day Quarter in the manner specified by the Department in the *PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual* by the applicable date in the following subsections.

b. Meet the definition of a nursing facility as defined in 55 Pa. Code § 1187.2 for the entire applicable Resident Day Quarter.

c. Have an overall occupancy rate of at least 85% during the applicable Resident Day Quarter.

d. Have a MA occupancy rate of at least 65% during the applicable Resident Day Quarter.

(iii) For purposes of subsection (a)(ii) above, Overall occupancy rate = (Total Resident Days ÷ (licensed bed capacity at the end of the quarter x the number of calendar days in the quarter)). MA occupancy rate = Total PA MA days ÷ Total Resident Days.

(iv) The Department will use the Total PA MA days and the Total Resident Days defined in the *PA NF Assessment and Quarterly Resident Day Reporting Form End User Manual* as reported by nursing facilities on the applicable nursing facility assessment resident day reporting forms to determine eligibility and calculate payments.

(b) For FY 2018-2019, qualifying nursing facilities in the southwest Community HealthChoices (CHC) zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2018 for the July 1, 2017 – September 30, 2017 Resident Day Quarter for the first payment and January 31, 2019 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For all other qualifying nursing facilities, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2018 for the April 1, 2018 – June 30, 2018 Resident Day Quarter for the first payment and January 31, 2019 for the July 1, 2018 – September 30, 2018 Resident Day Quarter for the second payment.

(c) For FY 2019-2020, qualifying nursing facilities in the southwest CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2019 for the July 1, 2017 – September 30, 2017 Resident Day Quarter for the first payment and January 31, 2020 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For qualifying nursing facilities in the southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2019 for the July 1, 2018 – September 30, 2018 Resident Day Quarter for the first payment and January 31, 2020 for the October 1, 2018 – December 31, 2018 Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2019 for the April 1, 2019 – June 30, 2019 Resident Day Quarter for the first payment and January 31, 2020 for the July 1, 2019 – September 30, 2019 Resident Day Quarter for the second payment.

(d) For FY 2020-2021, for qualifying nursing facilities in the southwest CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2020 for the July 1, 2017 – September 30, 2017 Resident Day Quarter for the first payment and January 31, 2021 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For qualifying nursing facilities in the southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2020 for the July 1, 2018 – September 30, 2018 Resident Day Quarter for the first payment and January 31, 2021 for the October 1, 2018 – December 31, 2018 Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2020 for the July 1, 2019 – September 30, 2019 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2021 for the October 1, 2019 – December 31, 2019 Resident Day Quarter for the second payment.

(e) For FY 2021-2022, for qualifying nursing facilities in the southwest CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2021 for the July 1, 2017 – September 30, 2017 Resident Day Quarter for the first payment and January 31, 2022 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For qualifying nursing facilities in the southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2021 for the July 1, 2018 – September 30, 2018 Resident Day Quarter for the first payment and January 31, 2022 for the October 1, 2018 – December 31, 2018 Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2021 for the July 1, 2019 – September 30, 2019 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2022 for the October 1, 2019 – December 31, 2019 Resident Day Quarter for the second payment.

(f) For FY 2022-2023, qualifying nursing facilities in the southwest Community HealthChoices (CHC) zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2022 for the July 1, 2017 – September 30, 2017 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2023 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For qualifying nursing facilities in southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2022 for the July 1, 2018 – September 30, 2018 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2023 for the October 1, 2018 – December 31, 2018 Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2022 for the July 1, 2019 – September 30, 2019 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident reporting forms available on January 31, 2023 for the October 1, 2019 – December 31, 2019 Resident Day Quarter for the second payment.

(g) For FY 2023-2024, qualifying nursing facilities in the southwest Community HealthChoices (CHC) zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2023 for the July 1, 2017- September 30, 2017 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2024 for the October 1, 2017 – December 31, 2017 Resident Day Quarter for the second payment. For qualifying nursing facilities in the southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2023 for the July 1, 2018 - September 30,

2018 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2024 for the October 1, 2018 – December 31, 2018 Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2023 for the July 1, 2019 – September 30, 2019 Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2024 for the October 1, 2019 – December 31, 2019 Resident Day Quarter for the second payment.

(h) For FY 2024-2025, qualifying nursing facilities in the southwest Community HealthChoices (CHC) zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2024, for the July 1, 2017 – September 30, 2017, Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2025, for the October 1, 2017 – December 31, 2017, Resident Day Quarter for the second payment. For qualifying nursing facilities in the southeast CHC zone, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2024, for the July 1, 2018 – September 30, 2018, Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2025, for the October 1, 2018 – December 31, 2018, Resident Day Quarter for the second payment. For qualifying nursing facilities in the Lehigh/Capital, northwest and northeast CHC zones, the Department will use the nursing facility assessment quarterly resident day reporting forms available on October 31, 2024, for the July 1, 2019 – September 30, 2019, Resident Day Quarter for the first payment and will use the nursing facility assessment quarterly resident day reporting forms available on January 31, 2025, for the October 1, 2019 – December 31, 2019, Resident Day Quarter for the second payment.

(i) The Department will calculate each qualified nonpublic nursing facility's MDOI payments based on the following formula: (i) An MDOI per diem for each of the two MDOI payments will be ½ of the total funds appropriated for the fiscal year divided by the Total PA MA days as reported by all qualifying nursing facilities for the applicable Resident Day Quarter.

(ii) Each MDOI per diem will then be multiplied by each qualified nursing facility’s Total PA MA days, as reported, for the applicable Resident Day Quarter to determine its MDOI payment.

(iii) The Department will not retroactively revise an MDOI payment amount based on a nursing facility’s late submission or revision of its nursing facility assessment quarterly resident day report related to the dates above. The Department may

recoup payments based on an audit of a nursing facility's report.

(iv) The state funds allocated for nonpublic nursing facilities for a Fiscal Year is as follows:

FY 2018-2019 is $8,000,000.
FY 2019-2020 is $16,000,000.
FY 2020-2021 is $16,000,000.
FY 2021-2022 is $16,000,000.
FY 2022-2023 is $16,000,000.
FY 2023-2024 is $16,000,000.
FY 2024-2025 is $21,000,000.

6. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class The Department will make a nonpublic nursing facility supplementation payment in fiscal years (FY) 2015-2016 and 2016-2017 to qualified nonpublic nursing facilities located In a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.19 as of August 1, 2015. The number of beds will be the number of licensed beds as of August 1,2015 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2015 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A non-public nursing facility's supplementation payment is calculated by dividing the total funds available by the number of qualified nonpublic nursing facilities.

6a. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class:

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2018-2019 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.14 as of August 1, 2017. The number of beds will be the number of licensed beds as of August 1, 2017 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2017 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2018-2019 is $1,000,000.

6c. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2019-2020 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.14 as of August 1, 2018. The number of beds will be the number of licensed beds as of August 1, 2018 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2018 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2019-2020 is $1,000,000.

6d. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2020-2021 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.14 as of August 1, 2019. The number of beds will be the number of licensed beds as of August 1, 2019 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2019 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

6e. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2021-2022 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.18 as of August 1, 2020. The number of beds will be the number of licensed beds as of August 1, 2020 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2020 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2020-2021 is $1,000,000.
The state funds allocated for FY 2021-2022 is $1,000,000.

6f. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2022-2023 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.15 as of August 1, 2021. The number of beds will be the number of licensed beds as of August 1, 2021 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2021, Picture Date in accordance with 55 Pa.Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

6g. Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2023-2024 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds, and a Medicaid acuity of 1.06 as of August 1, 2022. The number of beds will be the number of licensed beds as of August 1, 2022, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2022, Picture Date in accordance with 55 Pa.Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2022-2023 is $1,000,000.
The state funds allocated for FY 2023-2024 is $1,000,000.

6h. *Supplementation Payment for Nonpublic Nursing Facilities in a County of the First Class*

(a) The Department of Human Services (Department) will make a nonpublic nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the first class, have more than 395 beds and a Medicaid acuity of 1.06 as of August 1, 2022. The number of beds will be the number of licensed beds as of August 1, 2022, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2022, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

(b) A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY.

The state funds allocated for nonpublic nursing facilities for a FY are as follows:

FY 2024-2025 is $1,000,000.

7. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal years 2015-2016 and 2016-2017 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eight class, have more than 119 beds, and a Medicaid acuity of 1.14 as of August 1, 2015. The number of beds will be the number of licensed beds as of August 1, 2015 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2015 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by dividing the total funds available by the number of qualified nonpublic nursing facilities.

7a. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal years 2017-2018 and 2018-2019 to qualified nonpublic nursing facilities located in a county of the first class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eight class, have more than 119 beds, and a Medicaid acuity of 1.02 as of August 1, 2017. The number of beds will be the number of licensed beds as of August 1, 2017 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2017 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

A nonpublic nursing facility’s supplementation payment is calculated by multiplying the supplementation per diem by the number of paid MA facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year for qualifying facilities.

The state funds allocated for FYs 2017-2018 and 2018-2019 is as follows:

FY – 2017-2018 - $5,000,000
FY – 2018-2019 - $5,000,000

7b. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal year 2019-2020 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds, and a Medicaid acuity of 1.08 as of August 1, 2018. The number of beds will be the number of licensed beds as of August 1, 2018 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2018 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

7c. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal year 2020-2021 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds, and a Medicaid acuity of 1.09 as of August 1, 2019. The number of beds will be the number of licensed beds as of August 1, 2019 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2019 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid MA facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year for qualifying facilities.

7d. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal year 2021-2022 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds, and a Medicaid acuity of 1.04 as of August 1, 2020. The number of beds will be the number of licensed beds as of August 1, 2020 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2020 Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

7e. Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class

The Department will make a nonpublic nursing facility supplementation payment in fiscal year 2022-2023 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds, and a Medicaid acuity of 1.07 as of August 1, 2021. The number of beds will be the number of licensed beds as of August 1, 2021 and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2021 Picture Date in accordance with 55 Pa. Code §1187.33 (relating to resident data and picture date reporting requirements).

A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid MA facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year for qualifying facilities.

7f. *Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class*

The Department will make a nonpublic nursing facility supplementation payment in fiscal year 2023-2024 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds and a Medicaid acuity of 1.11 as of August 1, 2022. The number of beds will be the number of licensed beds as of August 1, 2022, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2022, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid MA facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year for qualifying facilities.

The state funds allocated for nonpublic nursing facilities for a FY is as follows:
FY 2019-2020 is $5,000,000.
FY 2020-2021 is $5,000,000.
FY 2021-2022 is $5,000,000.
FY 2022-2023 is $5,000,000.
FY 2023-2024 is $5,000,000.

7g. *Supplementation Payment for Nonpublic Nursing Facilities in a County of the Eighth Class*

(a) The Department of Human Services (Department) will make a nonpublic nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic nursing facilities located in a county of the eighth class. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a county of the eighth class, have more than 119 beds and a Medicaid acuity of 1.11 as of August 1, 2022. The number of beds will be the number of licensed beds as of August 1, 2022, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2022, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

(b) A nonpublic nursing facility’s supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY for qualifying facilities.

The state funds allocated for nonpublic nursing facilities for a FY are as follows:

FY 2024-2025 is $5,000,000.

8. Medical Assistance Dependency Payment for High Volume Special Rehabilitation Facilities

The Department will make a supplemental payment in Fiscal Year (FY) 2016-2017 to certain special rehabilitation facilities (SRFs) that have both a high Medical Assistance (MA) occupancy and a high total facility occupancy. The determination of whether a nursing facility qualifies for this supplemental. payment and the amount of the supplemental payment is based on the nursing facility's 12-month MA cost report with a reporting period ending either December 31, 2014 or June 30, 2015 and accepted on or before April 1, 2016.

To qualify for this supplemental payment a nursing facility must be classified as a SRF as of the cost report end date; have MA occupancy greater than or equal to 94% as reported on Schedule A, Column A Line 5 of the cost report; have an overall nursing facility occupancy greater than or equal to 95% as reported on Schedule A, Column A Line 4 of the cost report; and have at least 200 MA certified nursing facility beds as of the cost report end date. For FY 2016-2017 the payment to qualifying nursing facilities will be $40.55 times the number of MA days of care reported on their 12-month MA cost report with a reporting period ending either December 31, 2014 or June 30, 2015 and accepted on or before April 1, 2016.

8a. Medical Assistance Dependency Payment for High Volume Special Rehabilitation Facilities

The Department will make a supplemental payment in Fiscal Year(FY) 2017-2018 to certain special rehabilitation facilities (SRFs) that have both a high Medical Assistance (MA) occupancy and a high total facility occupancy. The determination of whether a nursing facility qualifies for this supplemental payment and the amount of the supplemental payment is based on the nursing facility's 12-month MA cost report with a reporting period ending either December 31, 2014 or June 30, 2015 and accepted on or before April 1, 2016.

To qualify for this supplemental payment a nursing facility must be classified as a SRF as of the cost report end date; have MA occupancy greater than or equal to 94% as reported on Schedule A, Column A Line 5 of the cost report; have an overall nursing facility occupancy greater than or equal to 95% as reported on Schedule A. Column A Line 4 of the cost report; and have at least 200 MA certified nursing facility beds as of the cost report end date. For FY 2017-2018 the payment to qualifying nursing facilities will be calculated by dividing the funds available by the number of qualified SRFs.

8b. Medical Assistance Dependency Payment for High Volume Special Rehabilitation Facilities

The Department will make a supplemental payment in Fiscal Years (FYs) 2018-2019 and 2019-2020 to certain special rehabilitation facilities (SRFs) that have both a high Medical Assistance (MA) beneficiary occupancy and a high total facility occupancy. The determination of whether a nursing facility qualifies for this supplemental payment and the amount of the supplemental payment is based on the nursing facility's 12-month MA cost report with a reporting period ending either December 31, 2014 or June 30, 2015 and accepted on or before April 1, 2016.

To qualify for this supplemental payment a nursing facility must be classified as a SRF as of the cost report end date; have MA beneficiary occupancy greater than or equal to 94% as reported on Schedule A, Column A Line 5 of the cost report; have an overall nursing facility occupancy greater than or equal to 95% as reported on Schedule A, Column A Line 4 of the cost report; and have at least 200 MA certified nursing facility beds as of the cost report end date. For FYs 2018-2019 and 2019-2020 the payment qualifying nursing facilities will be calculated by multiplying the supplementation per diem by the number of paid MA facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

9. Payment to a Special Rehabilitation Facility in a City of the Third Class

The Department will make a payment in the Fiscal Years 2016-2017 and 2017-2018 to a qualified special rehabilitation facility (SRF) in peer group 13 located in a city of the third class. To qualify, the SRF must be located in a city of the third class with a population between 115,000 and 120,000 based on U.S. CensusBureau; 2010 Census Summary using American FactFinder; http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml. A SRF's payment is calculated by dividing the total funds available by the number of qualified SRFs.

The state funds allocated for FY 2017-2018 is $850,000.

9a. Payment to a Special Rehabilitation Facility in a City of the Third Class

The Department will make a payment in Fiscal Years (FYs) 2018-2019 and 2019-2020 to a qualified special rehabilitation facility (SRF) in peer group 13 located in a city of the third class. To qualify, the SRF must be located in a city of the third class with a population between 115,000 and 120,000 based on U.S> Census Bureau; 2010 Census Summary using American FactFinder; http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

The Department will calculate a SRF's payment by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2018-2019 is $850,000.
The state funds allocated for FY 2019-2020 is $850,000.

9b. Payment to a Special Rehabilitation Facility in a City of the Third Class

The Department will make a payment in Fiscal Years (FYs) 2022-2023 to a qualified special rehabilitation facility (SRF) in peer group 13 located in a city of the third class. To qualify, the SRF must be located in a city of the third class with a population between 115,000 and 120,000 based on U.S. Census Bureau; 2020 Census Summary using https://data.census.gov. The Department will calculate a SRF's payment by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state fund allocated for FY 2022-2023 IS $500,000.

10. Supplemental Ventilator Care and Tracheostomy Care Add-on Payment

The Department will make payments in fiscal years (FYs) 2016-2017, 2017- 2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022 and 2022-2023 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015 and remain open as of July 11, 2022. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance residents who required medically necessary ventilator care or tracheostomy care greater than 90 percent using the quarterly payment files located on the Department's website.

10a. The Department will make payments in FY 2023-2024 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015 and remain open as of December 13, 2023. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance residents who required medically necessary ventilator care or tracheostomy care greater than 90 percent using the quarterly payment files located on the Department's website. The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY is as follows:

FY 2017-2018 is $750,000.
FY 2018-2019 is $1,500,000.
FY 2019-2020 is $750,000.
FY 2020-2021 is $750,000.
FY 2021-2022 is $750,000.
FY 2022-2023 is $500,000.
FY 2023-2024 is $500,000.

10b. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment*

(a) The Department of Human Services (Department) will make payments in Fiscal Year (FY) 2024-2025 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015 and remain open as of July 11, 2024. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance (MA) residents who required medically necessary ventilator care or tracheostomy care greater than 90% using the quarterly payment files located on the Department's website.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $500,000.

11. Supplementation Payment for Nonpublic Special Rehabilitation Nursing Facilities in a County of the First Class

The Department will make a nonpublic nursing facility supplementation payment in Fiscal Year 2020-2021 to qualified special rehabilitation nursing facilities located in a county of the first class. To qualify, a special rehabilitation facility in Peer Group number 13 must be located in a county of the first class, have more than 55 beds and a Medicaid acuity of 1.43 as of May 1, 2020. The number of beds will be the number of licensed beds as of May 1, 2020, and the Medicaid acuity will be determined using the Case Mix Index Report for the May 1, 2020, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A nonpublic nursing facility's supplementation payment is calculated by dividing the total funds for the supplemental payment by the number of qualified nonpublic nursing facilities.

The state funds allocated for FY 2020-2021 is $351,000.

12. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment for Nonpublic and County Nursing Facilities in a Township of the First Class in a County of the Second Class A*

(a) The Department of Human Services (Department) will make a ventilator care and tracheostomy care add-on payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic and county nursing facilities located in a township of the first class in a county of the second class A. To qualify, a nonpublic and county nursing facility must be located in a township of the first class in a county of the second class A and remain open as of July 11, 2024, with a percentage of Medical Assistance (MA) recipient residents who required medically necessary ventilator care or tracheostomy care equal to or greater than 90% as of August 1, 2022.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $250,000.

13. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment for Nonpublic and County Nursing Facilities in a City of the First Class*

(a) The Department of Human Services (Department) will make a ventilator care and tracheostomy care add-on payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic and county nursing facilities located in a city of the first class. To qualify, a nonpublic and county nursing facility must be located in a city of the first class, have commenced operations after December 31, 2017, and remain open as of July 11, 2024, with a percentage of Medical Assistance (MA) recipient residents who required medically necessary ventilator care or tracheostomy care equal to or greater than 90% as of August 1, 2022.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $250,000.

14. *Supplementation Payment for Nonpublic Nursing Facilities in a Home Rule County that is a County of the Second Class A*

(a) The Department of Human Services (Department) will make a nonpublic nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic nursing facilities located in a home rule county that is a county of the second class A. To qualify for the supplementation payment, a nonpublic nursing facility must be located in a home rule county that is a county of the second class A, have more than 126 beds and have a Medicaid acuity of 0.89 as of February 1, 2023. The Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the February 1, 2023, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

(b) A nonpublic nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY for qualifying facilities.

The state funds allocated for nonpublic nursing facilities for a FY are as follows:

FY 2024-2025 is $1,500,000.

15. *Supplementation Payment for Nonprofit Nursing Facilities in a City of the Second Class A in a County of the Third Class*

(a) The Department of Human Services (Department) will make a nonprofit nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nonprofit nursing facilities located in a city of the second class A in a county of the third class. To qualify for the supplementation payment, a nonprofit nursing facility must be located in a city of the second class A in a county of the third class and have a Medicaid acuity of 1.11 as of February 1, 2023. The Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the February 1, 2023, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

(b) A nonprofit nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY for qualifying facilities.

The state funds allocated for nonprofit nursing facilities for a FY are as follows:

FY 2024-2025 is $1,500,000.

J. Exceptional Payments

1. Exceptional Payment Agreements Prior to January 1, 1996

Prior to January 1, 1996, the Department entered into exceptional payment agreements to provide additional payments for certain services/supplies which included ventilator rental equipment, supplies necessary because of ventilator dependency, respiratory hours, additional nursing hours and intensive head injury programs with extensive physical, speech and occupational therapy to high technology-dependent residents, such as ventilator dependent and head and/or spinal cord injured individuals. The Department will continue to make payment under exceptional payment agreements for residents who were receiving services/supplies under this program prior to the implementation of the case-mix payment system on January 1, 1996 until these services/supplies are no longer needed or desired by the resident; upon 30 day written notice to the nursing facility; or upon the nursing facility's breach of the agreement.

2. Exceptional Payments During the Period January 1, 1996 through October 31, 1999.

Beginning on January 1, 1996, the Department began entering into Exceptional Payment Agreements in accordance with the following provisions: With the implementation of the case-mix payment system, in limited instances, the Department entered into exceptional payment agreements with participating nursing facilities to make payments in addition to the nursing facilities' case-mix per diem rate for high technology-dependent residents, such as ventilator dependent and head and/or spinal cord injured individuals. To receive exceptional payments for a high technology-dependent resident, a nursing facility had to demonstrate to the satisfaction of the Department that its case-mix per diem rate did not cover the additional exceptional costs that the nursing facility incurred to care for the resident.

If the Department was satisfied that the nursing facility's case-mix per diem rate did not cover the additional exceptional costs related to the care of the high technology-dependent resident and that the resident could not otherwise. obtain appropriate care, the Department could enter into an exceptional payment agreement to pay for additional costs necessary for the care of the exceptional resident. These additional costs were limited to the rental of equipment and: the supplies necessary to care for high technology-dependent residents.

The Department entered into an individual exceptional payment agreement for each exceptional resident and negotiated with the nursing facility the additional costs to be paid thereunder on a case-by-case basis.

The Department does periodic physician assessments of each exceptional resident to determine what the resident's current special medical needs are and how these needs can be met.

To receive payments for an exceptional resident, the nursing facility bills its case-mix rate for the resident. The nursing facility also submits a separate invoice each month for items specified in the exceptional payment agreement. The nursing facility must attach documentation to the monthly invoice verifying what special services/supplies were actually received by the resident for the month. The Department reviews the documentation and authorizes payment with the exceptional payment agreement only for services/supplies received by the resident for the applicable month and covered under the exceptional payment agreement.

During the audit, the Department ensures that the nursing facility adjusts its reported costs on the cost report to account for the exceptional reimbursement. Payment by the Department of the rates permitted by the exceptional payment agreement shall be payment in full for additional nursing facility services/supplies (above the customary MA covered services) required and received by the specified resident.

The Department will continue to make payments under exceptional payment agreements entered into during the period January 1, 1996, through October 31, 1999, in accordance with and subject to the terms and conditions in those agreements.

3. Exceptional Payments on or after November 1, 1999.

Beginning November 1, 1999, in addition to payments based upon the nursing facility's case-mix per diem rate the Department will issue exceptional Durable Medical Equipment (DME) grants that authorize payments for certain exceptional nursing facility services involving the purchase or rental of exceptional DME. For purposes of these grants, exceptional DME must have: a minimum acquisition cost that is equal to or greater than an amount specified by the Department and is either specially adapted DME or such other DME that is designated as exceptional DME by the Department. The Department will identify the minimum exceptional DME acquisition cost and other designated exceptional DME annually by notice in the Pennsylvania Bulletin.

To receive an exceptional DME grant for a resident, a nursing facility must submit a request on forms designated by the Department. The Department will issue an exceptional DME grant if the Department determines that: (1) the nursing facility's request complies with all applicable Department instructions; (2) the DME specified in the nursing facility's request is medically necessary; (3) the DME specified in the nursing facility's request is exceptional DME; (4) the nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME; (5) the nursing facility has exhausted all third party medical resources, and; (6) during the period November 1, 1999 through June 30, 2001, the nursing facility has executed a written grant agreement on a form designated by the Department or, effective July 1,2001 and thereafter, the facility certified to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

When the Department issues an exceptional DME grant to a nursing facility, the Department identifies the resident to whom the exceptional services are being provided, the specific equipment and related services paid by the exceptional DME grant, the amount of the exceptional payment(s), and the terms and conditions under which the payment(s) will be made. An exceptional DME grant is effective on the date specified in the nursing facility's grant and ends on the date the exceptional DME grant is terminated pursuant to § 1187.156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments) .

The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following: (1) The lower of the nursing facility's costs to obtain the exceptional DME and related services and items; or, in the event the nursing facility is obtaining the exceptional DME or related services and items from a related party as defined in 55 Pa. Code § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the nursing facility; (2) The applicable MA outpatient fee schedule amount, if any; or, (3) Eighty percent (80%) of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

The amount of the exceptional payment(s) authorized by the exceptional DME grant are deemed to be the necessary, reasonable and prudent costs of the exceptional DME and the related services and items identified in the nursing facility's exceptional DME grant.

The exceptional payment is paid in either lump sum or monthly payments depending on which method is in the best interest of the MA program. Authorization for monthly payments continues during the term of the nursing facility's grant except during. a period of suspension as specified in §1187 .156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

All nursing facility services provided by a nursing facility receiving an exceptional OME grant, including services paid by the grant, remain subject to applicable federal and state laws and regulations, including the laws and regulations governing the MA Program.

Nursing facility services paid by an exceptional DME grant are subject to review by the Department to ensure compliance with the terms and conditions of the exceptional DME grant. The Department will perform periodic assessments of each resident receiving nursing facility services paid by an exceptional DME grant to determine the continuing need for the exceptional DME.

The Department will conduct audits to ensure that a nursing facility receiving payment authorized by an exceptional DME grant adjusts its reported costs on the cost report to account for the exceptional payments. Payments(s) received by a nursing facility involving exceptional DME related services and items.

K. Related Provisions

1. Supplemental I contains the Department's Chapter 1187 Nursing Facility Service Regulations.

2. Supplemental II contains the upper payment limit phase-out for State fiscal years 2003-2004 through 2009-2010.

3. The RUG-III index scores peer groups; and the Financial and Statistical Report form (MA-11) are available for review upon request.

The Commonwealth of Pennsylvania has in place a process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Methods and Standards for Governing Payment for Nursing Facility Services

Citation

42 CFR 447,434,438, and 1902(a){4), 1902(a}(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a){6), and 1903 with respect to non-payment for provider-preventable conditions,

Other Provider Preventable Conditions (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19D.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider· Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other Invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.

(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) Reductions In provider payment may be limited to the extent that the following apply:
a. The identified PPC will otherwise result in an increase in payment. .
b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC,

(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

2023 Enhanced Supplemental Payment.

For state fiscal year 2023-2024, the Department will allocate a total of Forty Million Dollars ($40,000,000.00) (state and federal financial participation combined) to offer a one-time enhanced supplemental payment ("2023 ES Payment) to eligible public and non-public facilities enrolled in and certified for participation in the MA Program to further address the economic impact of the novel Coronavirus Disease of 2019 ("COVID-19") on those facilities, as follows:

a. Qualified Nursing Facilities. The Department will offer a 2023 ES Payment to a nursing facility that satisfies the following:

- The facility's NIS Provider ID must be on the list at https://www.dhs.pa.gov/providers/Providers/Pages/Rates-Nursing%20Facilites.aspx

Nursing facilities that satisfy the above condition are referred to plurally as "Qualified Nursing Facilities," and singularly as a "Qualified Nursing Facility."

b. Amount of the Payment. The amount of the 2023 ES Payment that Department will offer to each Qualified Nursing Facility is set forth on the list at https://www.dhs.pa.gov/providers/Providers/Pages/Rates-Nursing%20Facilites.aspx

c. Additional Requirements to Receive the 2023 ES Payment. To accept and to receive the 2023 ES Payment, the Qualified Nursing Facility also must satisfy the following additional conditions:

(i) the Qualified Nursing Facility must be enrolled in and certified for participation in the MA Program on the date the Department pays the 2023 ES Payment; and

(ii) the Qualified Nursing Facility must sign an acceptance and release form and submit it to the Department subject to the following:

(A) The Department must receive the form no later than a deadline set by the Department. The deadline for the Department's receipt of the form shall be no sooner than sixty (60) days after the date that the Department sends the form to the Qualified Nursing Facility either by electronic means or by regular mail, whichever date is earlier.

(B) Under the release, the Qualified Nursing Facility must agree to release the Department from any and all claims for additional money or payments related in any way to:

(1) the increased federal financial participation (FFP) that resulted from the enhanced federal medical assistance percentage (Enhanced FMAP) enacted under Section 6008(a) of the Families First Coronavirus Response Act, P.L. 116-127 (March 18, 2020) effective January 1, 2020 and extended through the last calendar quarter including the federal Novel Coronavirus Disease of 2019 (COVID-19) public health emergency and as long as the federal government determines (the duration is referred to as the "Relevant Time Period"); or

(2) the state Nursing Facility Assessment Program set forth in Pennsylvania statute for the Relevant Time Period as it relates to the increased FFP that resulted from the Enhanced FMAP.

(C) The Department will not, in any way, require the Qualified Nursing Facility to waive any claims for services.

d. Changes of Ownership. If there is a change of ownership of a Qualified Nursing Facility since January 1, 2020, the Department will only pay the facility enrolled in and certified for participation in the MA Program at the time of the 2023 ES Payment and the Department will not pay any prior owner. In those cases, any purported rights to the 2023 ES Payment will be a matter between the current owner and any past owners.

The state funds allocated for FY 2023-2024 is $18,350,000.

TITLE 55. PUBLIC WELFARE
CHAPTER 1187. NURSING FACILITY SERVICES

SUBCHAPTER A. GENEML PROVISIONS

SUBCHAPTER B. SCOPE OF BENEFITS

SUBCHAPTER C. NURSING FACILITY PARTICIPATION

SUBCHAPTER D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

SUBCHAPTER E. ALLOWABLE PROGMM COSTS AND POLICIES

SUBCHAPTER F. COST REPORTING AND AUDIT REQUIREMENTS

SUBCHAPTER G. RATE SETTING

SUBCHAPTER H. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

SUBCHAPTER I. ENFORCEMENT OF COMPLIANCE FOR NURSING FACILITIES WITH DEFICIENCIES.

SUBCHAPTER J. NURSING FACILITY RIGHT OF APPEAL

SUBCHAPTER K. EXCEPTIONAL PAYMENT FOR NURSING FACILITY SERVICE

Subchapter A. GENERAL PROVISION

§ 1187.1. Policy.

(a) This chapter applies to nursing facilities, and to the extent specified in Chapter 1189 (relating to county nursing facility services), to county nursing facilities.

(b) This chapter governs MA payments to nursing facilities on the basis of the Commonwealth's approved State Plan for reimbursement.

(c) The MA Program provides payment for nursing facility services provided to eligible recipients by enrolled nursing facilities. Payment for services is made subject to this chapter and Chapter 1101 (relating to general provisions).

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of a cost report, resident assessment data, an appeal or amended appeal cannot be extended, except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed for nursing facilities by this chapter with respect to the filing of a cost report, resident assessment data, an appeal or an amended appeal may be permitted only upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code S 31.15 (relating to extensions of time).

§ 1187.2. Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Accrual basis - An accounting method by which revenue is recorded in the period when it is earned, regardless of when it is collected, and expenses are recorded in the period when they are incurred, regardless of when they are paid.

Allowable costs - Costs as identified in this chapter which are necessary and reasonable for an efficiently and economically operated nursing facility to provide services to MA residents.

Amortization - administrative costs - Costs not directly related to capital formation which are expended over a period greater than 1 year.

Amortization – capital costs - Preopening and ongoing costs directly related to capital formation and development which are expended over a period greater than 1 year. These costs include loan acquisition expenses as well as interest paid during the construction or preopening purchase period on a debt to acquire, build or carry real property.

Appraisal - A determination of the depreciated replacement cost of fixed or movable property, made by qualified personnel of an independent appraisal firm under contract with the Department.

*Audited M*A-11 cost reports - MA-1 1 cost reports that have been subjected to desk or field audit procedures by the Commonwealth and issued to providers.

Bed cost imitation - The fixed property cost limited by the amount identified in $ 1187.112 (relating to cost per bed limitation adjustment).

Benefits, fringe - Nondiscriminatory employee benefits which are normally provided to nursing facility employees in conjunction with their employment status.

Benefits, nonstandard or nonuniform - Employee benefits provided to selected individuals, which are not provided to all nursing facility employees in conjunction with their employment status, or benefits which are not normally provided to employees.

CMI - Case-Mix Index - A number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident.

CMI Report - A report generated by the Department from submitted resident assessment records and tracking forms and verified by a nursing facility each calendar quarter that identifies the total facility and MA CMI average for the picture date, the residents of the nursing facility on the picture date and the following for each identified resident:

(i) The resident's payor status.

(ii) The resident's RUG category and CMI.

(iii) The resident assessment used to determine the resident’s RUG category and CMI and the date and type of the assessment.

Classifiable data element—A data element on the Federally Approved Pennsylvania Specific Minimum Data Set (PA specific MDS) which is used for the classification of a resident into one of the RUG-III categories.

Cost centers—The four general categories of costs:

(i) Resident care costs.

(ii) Other resident related costs.

(iii) Administrative costs.

(iv) Capital costs.

County nursing facility—

(i) A long-term care nursing facility that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA program as a provider of nursing facility services.

(C) Controlled by the county institution district or by county government if no county institution district exists.

(ii) For the purposes of this definition ‘‘controlled’’ in clause (C) means the power to direct or cause to direct the management and policies of the nursing facility, whether through equitable ownership of voting securities or otherwise.

(iii) The term does not include intermediate care facilities for persons with an intellectual disability controlled or totally funded by a county institution district or county government.

DME—Durable medical equipment—

(i) Movable property that:

(A) Can withstand repeated use.

(B) Is primarily and customarily used to serve a medical purpose.

(C) Generally is not useful to an individual in the absence of illness or injury.

(ii) Any item of DME is an item of movable property. There are two classes of DME:

(A) *Exceptional DME.* DME that has a minimum acquisition cost that is equal to or greater than an amount specified by the Department by notice in the *Pennsylvania Bulletin* and is either specially adapted DME or other DME that is designated as exceptional DME by the Department by notice in the *Pennsylvania Bulletin*.

(B) *Standard DME.* Any DME, other than exceptional DME, that is used to furnish care and services to a nursing facility's residents.

Department—The Department of Human Services, which is the Commonwealth agency designated as the single State agency responsible for the administration of the Commonwealth's MA Program.

Department of Aging—The Commonwealth agency that, under a memorandum of understanding with the Department, conducts prescreening of target applicants applying for nursing facility services and the screening of MA nursing facility applicants to determine the need for services.

Department of Health—The Commonwealth agency that, under a memorandum of understanding with the Department, conducts certification surveys of nursing facilities in the MA Program.

Depreciated replacement cost—

(i) As used in conjunction with fixed property, depreciated replacement cost is the amount required to replace the fixed property with new and modern fixed property using the most current technology, code requirements/standards and construction materials that will duplicate the production capacity and utility of the existing fixed property at current market prices for labor and materials, less an allowance for accrued depreciation.

(ii) As used in conjunction with movable property, depreciated replacement cost is the amount required to replace the movable property with new and modern movable property, less an allowance for accrued depreciation.

Depreciation—A loss of utility and a reduction in value caused by obsolescence or physical deterioration such as wear and tear, decay, dry rot, cracks, encrustation or structural defects of property, plant and equipment.

FRV - Fair rental value - The imputed rent for the fixed or movable property used at a nursing facility to provide nursing facility services to its MA residents.

Facility MA CMI—The arithmetic mean CMI for MA residents in the nursing facility for whom the Department paid an MA day of care on the picture date.

Federally Approved Pennsylvania (PA) Specific Minimum Data Set (MDS)— A minimum core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

Financial yield rate—The composite Aaa Corporate Bond Yield Average as reported in Moody's Bond Record for the 60-month period ending in March of each year.

Fixed property—Land, land improvements, buildings including detached buildings and their structural components, building improvements, and fixed equipment located at the site of the licensed nursing facility that is used by the nursing facility in the course of providing nursing facility services to residents. Included within this term are heating, ventilating, and air-conditioning systems and any equipment that is either affixed to a building or structural component or connected to a utility by direct hook-up.

Hospital-based nursing facility—A nursing facility that was receiving a hospital-based rate as of June 30, 1995, and is:

(i) Located physically within or on the immediate grounds of a hospital.

(ii) Operated or controlled by the hospital.

(iii) Licensed or approved by the Department of Health and meets the requirements of 28 Pa. Code § 101.31 (relating to hospital requirements) and shares support services and administrative costs of the hospital.

Independent assessor—An agent of the Department who performs comprehensive evaluations and makes recommendations to the Department regarding the need for nursing facility services or the need for specialized services, or both, for individuals seeking admission to or residing in nursing facilities.

Initial appraisal - an appraisal of the fixed property of a new nursing facility, made for the . purpose of computing the fixed property component of that nursing facility's initial capital rate. An initial appraisal will be based, in part, upon an onsite inspection of the new nursing facility's fixed property conducted by qualified personnel of an independent appraisal firm under contract with the Department.

Initial Federally-approved PA Specific MDS—The first assessment or tracking form completed for a resident upon admission.

Interest—

(i) *Capital interest.* The direct actual cost incurred for funds borrowed to obtain fixed property, major movable property or minor movable property.

(ii) *Other interest.* The direct actual cost incurred for funds borrowed on a short-term basis to finance the day-to-day operational activities of the nursing facility, including the acquisition of supplies.

Intergovernmental Transfer Agreement—The formal document that executes the transfer of funds or certification of funds to the Commonwealth by another unit of government within this Commonwealth in accordance with section 1903 of the Social Security Act (42 U.S.C.A. § 1396b(w)(6)(A))

LTCCAP—Long-Term Care Capitated Assistance Program—The Department's community-based managed care program for the frail elderly based on the Federal Program of All-inclusive Care for the Elderly (PACE) (see section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee)).

Limited appraisal- An appraisal requested by a nursing facility and conducted to determine the effect of changes in the fixed property of a nursing facility, where the cost of the changes to the nursing facility was more than $200,000 or 10% of the most recent appraised depreciated replacement cost of the nursing facility's fixed property, whichever is lower. A limited appraisal results in the modification of the depreciated replacement cost set forth in an initial appraisal, a reappraisal, or an updated appraisal.

MA MCO—Medical Assistance Managed Care Organization—An entity under contract with the Department that manages the purchase and provision of health services, including nursing facility services, for MA recipients who are enrolled as members in the entity's health service plan.

MA conversion resident—A nursing facility resident who applies for and meets the eligibility requirements for MA payment for nursing facility services.

MA day of care - A day of care for which one of the following applies:

(i) The Department pays 100% of the MA rate for an MA resident.

(ii) The Department and the resident pay 100% of the MA rate for an MA resident.

(iii) An MA MCO or an LTCCAP provider that provides managed care to MA residents, pays 100% of the negotiated rate or fee for an MA resident's care.

(iv) The resident and either an MA MCO or LTCCAP provider that provides managed care to an MA resident, pays 1007of the negotiated rate or fee for an MA resident's care.

(v) The Department pays for care provided to an MA resident receiving hospice services in a nursing facility.

MA-11 - Financial and Statistical Report Schedules (uniform nursing facility cost report) - A package of certifications, schedules and instructions which makes up the comprehensive cost report.

MSA group - Metropolitan Statistical Area - A statistical standard classification designated and defined by the Federal Office of Management and Budget following aset of official published standards.

Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services (CMS) Pub. 15-1) - Guidelines and procedures for Medicare reimbursement.

Movable property -A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and that is not fixed property or a supply. There are two classes of movable property:

(i) Major movable property - Any movable property that has an acquisition cost of $500 or more.

(ii) Minor movable property -Any movable property that has an acquisition cost of less than $500.

Movable property appraisal- An appraisal of some or all of the movable property of a nursing facility. Depending upon circumstances, this appraisal may pertain to all movable property or only to major movable property. Movable property appraisals are conducted by qualified personnel of an independent appraisal firm under contract with the Department.

NIS—Nursing Information System—The comprehensive automated database of nursing facility, resident and fiscal information needed to operate the Pennsylvania Case-Mix Payment System.

Net operating costs—The following cost centers:

(i) Resident care costs.

(ii) Other resident related costs.

(iii) Administrative costs.

New nursing facility—A newly constructed, licensed and certified nursing facility; or an existing nursing facility that has never participated in the MA Program or an existing nursing facility that has not participated in the MA Program during the past 2 years.

Nursing facility—

(i) A long-term care nursing facility, that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by an individual, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include intermediate care facilities for persons with an intellectual disability, Federal or State-owned long-term care nursing facilities, Veteran's homes or county nursing facilities.

Peer groups—Groupings of nursing facilities for payment purposes under the case-mix system.

Pennsylvania Case-Mix Payment System—The nursing facility payment system which combines the concepts of resident assessments and prospective payment.

Per diem rate—A comprehensive rate of payment to a nursing facility for covered services for a resident day.

Picture date—The first calendar day of the second month of each calendar quarter.

Preadmission screening and resident review—The preadmission screening process that identifies target residents regardless of their payment source; and the resident review process that reviews target residents to determine the continued need for nursing facility services and the need for specialized services.

Price—A derivative of the allowable costs of the net operating cost centers which has been adjusted by 117% for resident care costs; 112% for other resident related costs; and 104% for administrative costs.

Private pay rate—The nursing facility's usual and customary charges made to the general public for a semiprivate room inclusive of ancillary charges.

Private pay resident—An individual for whom payment for services is made with the individual's resources, private insurance or funds from liable third parties other than the MA Program.

RNAC—Registered Nurse Assessment Coordinator—An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, and who is responsible for coordinating and certifying completion of the resident assessment.

RUG-III—Resource Utilization Group, Version III—A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.

Real estate tax cost—The cost of real estate taxes assessed against a nursing facility for a 12-month period, except that, if the nursing facility is contractually or otherwise required to make a payment in lieu of real estate taxes, that nursing facility's ''cost of real estate taxes'' is deemed to be the amount it is required to pay for a 12-month period.

Reappraisal - An appraisal of the fixed property of a nursing facility, made for the purpose of computing the fixed property component of that nursing facility's capital rate. A reappraisal will be based, in part, upon an onsite inspection of the nursing facility's fixed property conducted by qualified personnel of an independent appraisal firm under contract with the Department.

Rebasing—The process of updating cost data for subsequent rate years.

Related party—A person or entity that is associated or affiliated with or has control of or is controlled by the nursing facility or has an ownership or equity interest in the nursing facility. The term ''control,'' as used in this definition, means the direct or indirect power to influence or direct the actions or policies of an organization, institution or person.

Related services and items—Services and items necessary for the effective use of exceptional DME. The term is limited to:

(i) Delivery, set up and pick up of the equipment.

(ii) Service, maintenance and repairs of the equipment to the extent covered by an agreement to rent the equipment.

(iii) Extended warranties.

(iv) Accessories and supplies necessary for the effective use of the equipment.

(v) Periodic assessments and evaluations of the resident.

(vi) Training of appropriate nursing facility staff and the resident in the use of the equipment

Reorganized nursing facility—An MA participating nursing facility that changes ownership as a result of the reorganization of related parties or a transfer of ownership between related parties.

Resident assessment - A comprehensive, standardized valuation of each resident's physical, mental, psychosocial and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status and on an annual basis.

Resident Data Reporting Manual -The Department's Manual of instructions for submission of resident assessment records and tracking forms and verification of the CMI report.

Resident day -The period of service for one resident for a continuous 24 hours of service. The day of the resident's admission discounted as a resident day. The day of discharge is not counted as a resident day.

Resident personal funds - Funds entrusted to a nursing facility by a resident which are in the possession and control of a nursing facility and are held, safeguarded, managed and accounted for by the facility in a fiduciary capacity for the resident.

Specially adapted DME - DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one resident, making its contemporaneous use by another resident unsuitable.

Special rehabilitation facility - A nursing facility with residents more than 70% oI whom have a neurological/neuromuscular diagnosis and severe functional limitation.

Supply—

(i) A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and is normally consumed either in a single use or within a single 12-month period.

(ii) Examples of supplies include:

(A) Resident care personal hygiene items such as soap, toothpaste, toothbrushes and shampoo.

(B) Resident activity supplies such as game and craft items.

(C) Medical supplies such as surgical and wound dressings, disposable tubing and syringes, and supplies for incontinence care such as catheters and disposable diapers.

(D) Dietary supplies such as disposable tableware and implements and foodstuffs.

(E) Laundry supplies such as soaps and bleaches

(F) Housekeeping and maintenance supplies such as cleaners, toilet paper, paper towels and light bulbs.

(G) Administrative supplies such as forms, paper, pens and pencils, copier and computer supplies.

Target applicant or *resident*—An individual with a serious mental illness, intellectual disability or other related condition seeking admission to or residing in a nursing facility

Total facility CMI—The arithmetic mean CMI of all residents regardless of the residents' sources of funding.

UMR—Utilization Management Review—An audit conducted by the Department's medical and other professional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents.

Updated appraisal - An appraisal of a nursing facility's fixed property that is based upon the depreciated replacement cost set forth in the nursing facility's initial appraisal or most recent reappraisal and brought forward to a new date. An updated appraisal does not involve an additional onsite inspection of the nursing facility's fixed property. The depreciated replacement costs set forth in an updated appraisal are determined through the application of factors to allow for appreciation and depreciation estimated to have taken place between the two appraisal dates.

Year one of implementation—The period of January 1, 1996, through June 30, 1996.

Year two of implementation—The period of July 1, 1996, through June 30, 1997.

Year three of implementation and thereafter—The period of July 1, 1997, through June 30, 1998, and each subsequent Commonwealth fiscal year.

Subchapter B.
SCOPE OF BENEFITS

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Subchapter C.
NURSING FACILITY PARTICIPATION

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§ 1187.23. Nursing facility incentives and adjustments

(a) The Department will make minimum occupancy adjustments to encourage nursing facility efficiency and economy associated with nursing facility occupancy. levels. If the nursing facility's overall nursing facility occupancy level is below 90%, the Department will make an adjustment to total nursing facility resident days as though the nursing facility were at 90% occupancy. The Department will apply this 90% occupancy adjustment to the administrative cost component and the capital cost center.

(b) The Department will pay a disproportionate share incentive to a nursing facility that has a high overall occupancy and a high proportion of MA residents in accordance with S 1 187.1 1 1 (relating to disproportionate share incentive payments.

Subchapter D.
DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

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§ 1187.33. Resident data and picture date reporting requirements.

(a) *Resident data and picture date requirements*. A nursing facility shall meet the following resident data and picture date reporting requirements:

(1) The nursing facility shall submit the resident assessment data necessary for the CMI report to the Department as specified in the *Resident Data Reporting Manual*.

(2) The nursing facility shall ensure that the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical records maintained by the nursing facility.

(i) The nursing facility's clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

(ii) The Federally approved PA specific MDS shall be coordinated and certified by the nursing facility's RNAC.

(iii) The records listed in this section are subject to periodic verification and audit.

(3) The nursing facility shall maintain the records pertaining to each Federally-approved PA Specific MDS record and tracking form submitted to the Department for at least 4 years from the date of submission.

(4) The nursing facility shall ensure that resident assessments accurately reflect the residents' conditions on the assessment date.

(5) The nursing facility shall correct and verify that the information in the quarterly CMI report is accurate for the picture date and in accordance with paragraph (6) and shall sign and submit the CMI report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter.

(6) The CMI report must include resident assessment data for every MA and every non-MA resident included in the census of the nursing facility on the picture date.

(i) A resident shall be included in the census of the nursing facility on the picture date if all of the following apply:

(A) The resident was admitted to the nursing facility prior to or on the picture date.

(B) The resident was not discharged with return not anticipated prior to or on the picture date.

(C) Any resident assessment is available for the resident from which data may be obtained to calculate the resident's CMI.

(ii) A resident who, on the picture date, is temporarily discharged from the nursing facility with a return anticipated shall be included in the census of the nursing facility on the picture date as a non-MA resident.

(iii) A resident who, on the picture date, is on therapeutic leave shall be included in the census of the nursing facility on the picture date as an MA resident if the conditions of § 1187.104(2) (relating to limitations on payment for reserved beds) are met on the picture date. If the conditions of § 1187.104(2) are not met, the resident shall be included in the census of the nursing facility as a non-MA resident.

(b) *Failure to comply with the submission of resident assessment data*.

(1) If a valid assessment is not received within the acceptable time frame for an individual resident, the resident will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

(2) If an error on a classifiable data element on a resident assessment is not corrected by the nursing facility within the specified time frame, the assumed answer for purposes of CMI computations will be ''no/not present.''

(3) If a valid CMI report is not received in the time frame outlined in subsection (a)(5), the facility will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

§ 1187.34. Requirements related to notices and payments pending resident appeals.

(a) The requirements relating to notices authorizing and discontinuing MA payments for nursing facility services are as follows:

(1) *Notices authorizing MA payment.*

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice authorizing MA nursing facility services for each MA conversion resident and for each MA applicant or recipient who is admitted as a resident.

(ii) The Department's notice authorizing MA nursing facility services will specify the effective date of coverage and the amount of money that the resident has available to contribute towards payment. The nursing facility is responsible to obtain the resident's share of the payment.

(2) *Notices discontinuing MA payment.*

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice discontinuing payment for MA nursing facility services for every resident who the Department determines is no longer eligible to receive MA nursing facility services. The Department's determination may be based upon a review conducted by the Department or the resident's attending physician.

(ii) The Department's notice discontinuing payment for MA nursing facility services will specify the effective date of the discontinuance of coverage, that the resident may appeal the notice within 30 days and that the resident must appeal within 10-calendar days of the date the notice was mailed in order for payments to continue pending the outcome of the hearing on the resident's appeal.

(b) The requirements relating to payments pending resident appeals and recovery of payments subsequent to appeals are as follows:

(1) *Payments pending appeal.*

(i) If the resident or a representative of the resident appeals the Department's notice discontinuing payment for MA nursing facility services within 10-calendar days of the date on which the notice was mailed to the resident, the Department will continue payments to the nursing facility for nursing facility services rendered to the resident pending the outcome of the hearing on the resident's appeal subject to paragraph (2).

(ii) If the resident or a representative of the resident does not appeal the Department's notice discontinuing payment for MA nursing facility services, or appeals after 10-calendar days from the date on which the notice was mailed to the resident, the Department will cease payment to the nursing facility for services rendered to the resident beginning on the effective date of the discontinuance of coverage specified in the notice or the date on which the resident was discharged from the facility, whichever date occurs first.

(2) *Payment recovery for services rendered pending appeal.* If a resident's appeal of a notice of discontinuance of payment for MA nursing facility services is denied, the Department will recover payments made to the nursing facility. The period for which the Department will recover payments will begin on the effective date of the discontinuance of coverage specified in the notice to the resident and end on the date on which payments were discontinued as a result of the outcome of the hearing on the resident's appeal or the date of the resident's discharge from the facility, whichever date occurs first.

Subchapter E

ALLOWABLE PROGMM COSTS AND POLICIES

§ 1187.51. Scope

(a) This subchapter sets forth principles for determining the allowable costs of nursing facilities.

(b) *The Medicare Provider Reimbursement Manual* (CMS Pub. 15-1) and the Federal regulations in 42 CFR Part 489 (relating to provider and supplier agreements) appropriate to the reimbursement for nursing facility services under the Medicare Program are a supplement to this chapter. If a cost is included in this subchapter as allowable, the CMS Pub. 15-1 and applicable Federal regulations may be used as a source for more detailed information on that cost. The CMS Pub. 15-1 and applicable Federal regulations will not be used for a cost that is nonallowable either by a statement to that effect in this chapter or because the cost is not addressed in this chapter or in the MA-11. The CMS Pub. 15-1 or applicable Federal regulations will not be used to alter the treatment of a cost provided for in this subchapter or the MA-11.

(c) The Department's payment rate for nursing facility services to eligible residents in participating nursing facilities includes allowable costs for routine services. Routine services may include the following:

(1) Regular room, dietary and nursing services, social services and other services required to meet certification standards, medical and surgical supplies and the use of equipment and facilities.

(2) General nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(3) Items furnished routinely and uniformly to residents, such as resident gowns, water pitchers, basins and bedpans.

(4) Items furnished, distributed to residents or used individually by residents in small quantities such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories and tongue depressors.

(5) Reusable items furnished to residents, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

(6) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

(7) Basic laundry services.

(8) Nonemergency transportation.

(9) Beauty and barber services.

(10) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or maintain the resident's physical and social capacities.

(d) Nursing facilities will receive payment for allowable costs in four general cost centers:

(1) Resident care costs.

(2) Other resident related costs.

(3) Administrative costs.

(4) Capital costs.

(e) Within the limits of this subchapter, allowable costs for purposes of cost reporting include those costs necessary to provide nursing facility services. These may include costs related to the following:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

(v) Medical director.

(vi) Utilization and medical review.

(vii) Social services.

(viii) Resident activities.

(ix) Volunteer services.

(x) Over-the-counter drugs.

(xi) Medical supplies.

(xii) Physical, occupational and speech therapy.

(xiii) Oxygen.

(xiv) Beauty and barber.

(xv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance, including the repair, maintenance and service of movable property.

(v) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility.

(vii) Advertising.

(viii) Travel/entertainment.

(ix) Telephone.

(x) Insurance.

(xi) Interest other than that disallowed under § 1187.59(a)(24) (relating to nonallowable costs).

(xii) Legal fees.

(xiii) Amortization—administrative costs.

(xiv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in connection with an activity identified in this paragraph.

(4) *Capital costs.*

(i) Assigned cost of fixed property.

(ii) Acquisition cost of major movable property.

(iii) Real estate tax cost

§ 1187.52. Allowable cost policies.

(a) The Department will incorporate a nursing facility's direct and indirect allowable costs related to the care of residents into the NIS database. The Department will consider these costs in the setting of prices.

(b) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in reporting allowable costs. For the cost to be allowable, short-term liabilities shall be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

§ 1187.53. Allocating cost centers.

(a) The nursing facility shall allocate costs between nursing facility and residential in accordance with the allocation bases established by the Department as contained in this chapter and the MA-11. If the nursing facility has its own more accurate method of allocation, it may be used only if the nursing facility receives written approval from the Department prior to the first day of the applicable cost report year.

(b) The absence of documentation to support allocation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved changes in bases shall result in disallowances being imposed for each affected line item.

§ 1187.54. Changes in bed complement during a cost reporting period.

(a) When the nursing facility's bed complement changes during a cost reporting period, the allocation bases are subject to verification at audit.

(b) The nursing facility shall keep adequate documentation of the costs related to bed complement changes during a cost reporting period. The nursing facility shall submit a supplemental Schedule C (computation and allocation of allowable cost), which identifies costs being allocated by the required statistical methods for each period of change.

§ 1187.55. Selected resident care and other resident related cost policies.

Policies for selected resident care and other resident related costs are as follows:

(1) *Drug services.*

(i) The costs of nonlegend drugs, such as laxatives, aspirin and antacids that are provided directly by a nursing facility from its own supply are allowable costs if the drugs are medically necessary and administered according to a physician's written order or prescription.

(ii) Costs of legend drugs are not allowable costs.

(iii) Costs related to a pharmacy consultant shall be reported as general administrative costs on the cost report.

(2) *Practitioner and therapy services.*

(i) Costs for practitioner and therapy services which are provided on a contract or salary basis by the nursing facility are allowable costs.

(ii) The direct and indirect costs associated with noncompensable cost centers, such as a pharmacy or space rented or used by an independent practitioner, are not allowable costs.

(3) *Volunteer and donated services of individuals.*

(i) The actual costs that a nursing facility incurs when the nursing facility regularly uses the services of volunteer or religious organizations in positions that are normally held by full-time employees who provide resident care or assist with the operation of the nursing facility are allowable costs. The following conditions and limitations apply:

(A) The costs shall be limited to the fair market value of customary compensation of full-time personnel who perform similar services.

(B) The costs shall be based on regular working hours, excluding overtime.

(C) The actual costs for these services shall be supported by substantiating documentation.

(D) The costs will be reimbursed as part of the net operating costs.

(ii) The Department will recognize costs as allowable for nonpaid workers only if the following conditions are met:

(A) The nonpaid workers shall be members of an organization of nonpaid workers.

(B) Membership of a nonpaid worker in the organization shall be substantiated by adequate documentation in the files of the organization of nonpaid workers.

(C) A legally enforceable agreement between the nursing facility and the organization of nonpaid workers shall exist and establish the nursing facility's obligation to remunerate the organization for services rendered. If the nursing facility's legal obligation to pay the organization of nonpaid workers is nullified by an offsetting legal obligation by the organization of nonpaid workers to pay or make a contribution to the nursing facility of all or part of the salary liability, the amount paid or contributed by the organization of nonpaid workers is not an allowable cost.

(iii) A payment made by the organization of nonpaid workers to the nursing facility for the nonpaid workers' maintenance, perquisites or fringe benefits shall be used as an offset to the total of the cost actually incurred by the nursing facility.

(iv) Staff services relating to the use of volunteer workers are allowable costs.

(4) *Pastoral services.*

(i) Salary costs for pastoral services rendered directly to residents by professional staff employed by, or under contract with, the nursing facility are allowable costs.

(ii) Costs for a chaplaincy training program and pastoral housing are not allowable costs.

§ 1187.56. Selected administrative cost policies.

Policies for selected administrative costs are as follows:

(1) *Administrative allowance.*

(i) The allowable administrative costs incurred by a nursing facility to provide services are subject to the following limitation: the allowable administrative costs will be determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs.

(ii) Home office cost allocations and management fees are subject to the following conditions and limitations:

(A) Home office cost allocations and management fees between related parties shall be reported without markup by the nursing facility.

(B) Costs which are not allowable, such as those related to nonworking officers or officers' life insurance, may not be included in home office allocations or management fees.

(C) Documentation relating to home office and management costs shall be provided to the Department's auditors upon request.

(D) Home office allocations, including administratively allowable depreciation and interest costs shall be reported on the administrative line in the MA-11.

(iii) A nursing facility providing nursing, residential and other services shall allocate the total administrative cost to nursing, residential and other services on the basis of a percentage of these costs to the total net operating costs.

(2) *Other interest allowance.*

(i) Other interest is an allowable administrative cost if it is necessary and proper. To be considered allowable, necessary and proper, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of the nursing facility and for a purpose related to resident care. Interest incurred to pay interest is nonallowable.

(ii) Other interest may not exceed that amount which a prudent borrower would pay as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1).

(iii) Other interest is allowable if paid on loans from the nursing facility's donor-restricted funds, the funded depreciation account or the nursing facility's qualified pension fund.

(iv) Moneys borrowed for the purchase or redemption of capital stock will be considered a loan for investment purposes. The interest paid on these borrowed funds is a nonallowable cost. The use of funds by the nursing facility for the redemption of capital stock will be considered as an investment of available funds.

(3) *Investment income.*

(i) Investment income is used to reduce allowable other interest unless the investment income is from one of the following:

(A) Gifts or grants of which the corpus and interest are restricted by the donor.

(B) Funded depreciation maintained in accordance with Federal regulations.

(C) The nursing facility's qualified pension fund, if the interest earned remains in the fund.

(D) Issuer specified designated capital bond funds or debt service reserve funds.

(ii) Investment income on funds found to be used for purposes other than their designated purpose or commingled with other funds will be used to reduce allowable administrative interest expense.

(4) *General administration expenses.*

(i) Salaries of the nursing facility's administrator, comptroller, purchasing agent, personnel director, pharmacy consultant and other persons performing general supervision or management duties are allowable as general administrative costs.

(ii) The salary or compensation costs of owners, operators or persons other than nursing facility employees shall be included as allowable costs only to the extent of their documented time and involvement in the required management of a nursing facility. These costs mean actual payment made during the cost reporting period on a current basis of salary or benefits for services rendered to the nursing facility.

(iii) If a person performs work customarily performed by different or several types of employees, the cost of the salary and other compensation allowable for the person shall be determined by the prorated customary salary and other compensation paid to employees for performing the same types of work. This cost is allowable only if adequate documentation verifying the cost is supplied by the nursing facility.

(iv) The allowable cost for a person performing necessary duties may not exceed the customary compensation and fringe benefits that an employee would normally receive while performing that work.

(5) *Contracted management services.*

(i) In lieu of home office allocations or management fees, a nursing facility may contract with a nonrelated management service. The cost of this contract shall be shown as an administrative cost and may not be allocated among other cost centers.

(ii) Management services contracted with a related party shall be treated as home office allocations.

§ 1187.57. Selected capital cost policies.

The Department will establish a prospective facility-specific capital rate annually for each nursing facility. That rate will consist of three components: the fixed property component, the movable property component, and the real estate tax component.

(1) Fixed property component,

(i) The Department will base the nursing facility's fixed property component on the depreciated replacement cost of the nursing facility's fixed property and the associated financial yield rate.

(ii) On an annual basis, the Department will determine the depreciated replacement cost of each nursing facility's fixed property as of March 31, and will use that determination in setting the fixed property component for the rate year beginning on the following July 1.

(iii) The basis for the Department's determination of the depreciated replacement cost of the nursing facility's fixed property will be the most recent of the following appraisals, as modified by any limited appraisals, as of March 31:

(A) An initial appraisal.

(B) A reappraisal.

(C) An updated Appraisal

(iv) An initial appraisal of the nursing facility's fixed property will be conducted for any new nursing facility.

(v) A reappraisal of the nursing facility's fixed property will be conducted at least every 5 years.

(vi) In situations where neither an initial appraisal nor a reappraisal has been done within the 12-month period preceding March 31 , the depreciated replacement cost will be based upon an updated appraisal.

(vii) A limited appraisal will be conducted if the nursing facility notifies the Department that a limited appraisal is needed. For the results of a limited appraisal to be included in the determination of a nursing facility's fixed property component for the next rate year, a limited appraisal must be requested by the nursing facility byJanuary3l of the preceding rate year.

(viii) The depreciated replacement cost of the nursing facility's fixed property is subject to the cost per bed limitation § 1187.112 (relating to cost per bed limitation adjustment) and, if applicable, the bed moratorium limitation § 1187.13 (relating to capital component payment limitation).

(ix) The cost to purchase, construct, or renovate the fixed property of the nursing facility will not be a factor in determining the appraise depreciated replacement cost.

(x) When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraise depreciated replacement cost as the former owner.

(xi) The appraisals of fixed property will be performed by qualified personnel from-an independent appraisal firm under contract with the Department.

(2) Movable property component

(i) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001, the Department will determine the movable property component of each nursing facility's capital rate as follows:

(A) The Department will base the nursing facility's movable property component on the depreciated replacement cost of the nursing facility's major and minor movable property and the associated financial yield rate.

(B) On an annual basis, the Department will determine the depreciated replacement cost of each nursing facility's movable property as of March 31, and will use that determination in setting the movable property component for the rate year beginning on the following July 1.

(C) The Department will base the determination of the depreciated replacement cost of each nursing facility's movable property on a movable property appraisal.

(D) When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraised depreciated replacement cost as the former owner.

(ii) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001 , the Department will determine the movable property component of each nursing facility's capital rate as follows:

(A) The Department will base the nursing facility's movable property component on the nursing facility's audited cost of major movable property, as set forth in that MA-11.

(B) Each nursing facility shall report the acquisition cost of all major movable property on the major movable property line of its MA-11 and shall report the cost of minor movable property and the cost of supplies as net operating costs in accordance with § 1187.51 (relating to scope) and instructions for the MA-11.

(3) Real estate tax cost component. A nursing facility's real estate tax component will be based solely upon the audited cost of that nursing facility's 12-month real estate tax cost, as set forth on the most recent audited MA-1 1 cost report available in the NIS database.

§ 1187.58. Costs of related parties.

Costs applicable to services, movable property and supplies, furnished to the nursing facility by organizations related to the nursing facility by common ownership or control shall be included as an allowable cost of the nursing facility at the cost to the related organization. This cost may not exceed the price of comparable services, movable property or supplies that could be purchased elsewhere.

§ 1187.59. Nonallowable costs.

(a) *Nonallowable costs related to expenses and revenues.* The Department will not recognize as allowable costs the expenses or revenues of a nursing facility related to:

(1) Nonworking officers' or owners' salaries.

(2) Fundraising expenses for capital and replacement items exceeding 5% of the amount raised and, for operating expenses and cash flow, fundraising expenses exceeding 10% of the amount raised.

(3) Free care or discounted services.

(4) Parties and social activities not related to resident care.

(5) Organizational memberships not necessary to resident care.

(6) Personal telephone service.

(7) Personal television service.

(8) The direct and indirect costs related to nonallowable cost centers, including gift, flower and coffee shops, homes for administrators or pastors, convent areas and nurses' quarters, except as provided in § 1187.55(3) (relating to selected resident care and other resident related cost policies).

(9) Vending machines.

(10) Charitable contributions.

(11) Employee and guest meals.

(12) Pennsylvania Capital Stock and Franchise Tax.

(13) Income tax.

(14) Ambulance costs.

(15) Promotional advertising, including a yellow page listing larger than a minimum insert.

(16) Late payment penalties.

(17) Taxes based upon net income.

(18) Officers' and directors' life insurance, including life insurance premiums necessary to obtain mortgages and other loans.

(19) Bad debts or contractual adjustments.

(20) Collection expenses associated with bad debts.

(21) Losses on the sale of fixed and movable assets.

(22) Remuneration of any kind for any purpose, including travel expenses for members of the Board of Directors.

(23) Dry cleaning, mending or other specialty laundry services.

(24) Depreciation on fixed or movable property, capital interest, amortization—capital costs and rental expense for fixed property.

(25) Expenses or revenues not necessary to resident care.

(26) Costs, including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of a capital asset—by acquisition or merger—for which payment has previously been made under Title XVIII of the Social Security Act (42 U.S.C.A. § § 1395—1395yy) if the sale or purchase was made on or after July 18, 1984.

(27) Letter of credit costs.

(28) Legal expenses related to an appeal or action challenging a payment determination under this chapter until a final adjudication is issued sustaining the nursing facility's appeal. If the nursing facility prevails on some but not all issues raised in the appeal or action, a percentage of the reasonable legal expenses is allowable based upon the proportion of additional reimbursement received to the total additional reimbursement sought on appeal.

(29) Nonstandard or nonuniform fringe benefits.

(30) Return on net equity and net worth.

(b) *Nonallowable costs related to revenue producing items.* In determining the operating costs of a nursing facility, the Department will not allow costs related to:

(1) The sale of laundry and linen service.

(2) The sale of drugs to nonresidents.

(3) The sale of medical and surgical supplies to nonresidents.

(4) The sale of clinical records and abstracts.

(5) The rental of quarters to employees and others.

(6) The rental of space within the nursing facility.

(7) The payments received from clinical specialists.

(8) Discounts on purchases which include trade, quantity and time.

(9) Rebates and refunds of expenses.

(c) *Income that reduces allowable costs.*

(1) Except as provided in § 1187.56(3)(i) (relating to selected administrative cost policies), any form of investment income shall be used to reduce the allowable administrative interest expense.

(2) Grants, gifts and income designated by the donor for specific operating expenses are used to reduce the allowable costs relating to the specific operating expense.

(3) Recovery of insured loss shall be used to reduce the allowable costs relating to the insured loss.

(4) Applicable revenue producing items, other than room and board, shall be used to reduce the related allowable costs.

(5) Payments received under an exceptional DME grant reduce the allowable cost of the major movable property and related services and items in the cost centers where the costs were originally reported in the MA-11.

(d) *Nonallowable direct nursing facility payments.* Costs for prescription drugs, physician services, dental services, dentures, podiatry services, eyeglasses, appliances, X-rays, laboratory services and other materials or services covered by payments, other than MA or Medicare Part A, made directly to nursing facilities, including Medicare Part B, Champus, Blue Cross, Blue Shield or other insurers or third parties, are not allowable in determining net operating costs.

§ 1187.60. Prudent buyer concept.

The purchase or rental by a nursing facility of services, movable property and supplies, including pharmaceuticals, may not exceed the cost that a prudent buyer would pay in the open market to obtain these items, as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1)

§ 1187.61. Movable property cost policies.

(a) *Actual acquisition cost during cost report period.* Except as otherwise specified in this section and subject to § § 1187.58 and 1187.60 (relating to costs of related parties; and prudent buyer concept), a nursing facility's allowable movable property shall be limited to the nursing facility's actual acquisition cost of movable property placed in service during the cost report period.

(b) *Determination of acquisition cost.* Except in situations where an item of movable property is obtained from a related party, the acquisition cost of that item shall be determined as follows:

(1) Acquisition cost is determined on a per-unit basis.

(2) When an item is purchased, the acquisition cost of that item is equal to the total actual purchase price of the item, regardless of whether the total price is paid in full at the time of purchase or over a period of time, plus the following: any required sales tax, shipping charges and installation charges.

(3) When an item of movable property is leased or rented, the acquisition cost is limited to the lower of: the actual annual lease or rental payments made by the nursing facility; or the imputed purchase price of the item, pro-rated on a straight-line basis over the useful life of the item, as identified in the most recent Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association at the time the item is leased or rented. For purposes of this section, the imputed purchase price of a leased or rented item is the lesser of:

(i) The suggested list price from the manufacturer of the item.

(ii) The actual discounted price of the item available at the time of lease or rental.

(iii) The purchase price for the item set forth in the lease or rental agreement.

(iv) If the lessor is a related party, the related party's acquisition cost as determined in accordance with paragraph (2).

(4) When an item is acquired as the result of a gift or donation, the acquisition cost of that item is deemed to be the appraised depreciated replacement cost of the item provided that, on a date prior to the submission of the MA-11 for the period in which the item is acquired, the nursing facility obtains an appraisal of the item's depreciated replacement cost from a licensed appraiser and submits a copy of the written report of the appraisal to the Department with its MA-11. If the nursing facility fails to obtain an appraisal of the item's depreciated replacement cost from a licensed appraiser within the time period set forth in this section or if the nursing facility fails to submit a copy of the written report of the appraisal to the Department with its MA-11, the acquisition cost of the donated item or gift is deemed to be $0.

(5) When an item is acquired by a trade-in, the acquisition cost of the item shall be the sum of the remaining book value of the item traded-in plus any acquisition cost of the newly acquired item, computed in accordance with paragraphs 2, 3 and 4. The remaining book value of the item shall be determined based upon the useful life of the item, using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(6) When an item is loaned to the nursing facility without charge, the acquisition cost of that item is deemed to be $0.

(7) When an item is covered by a standard express warranty, the cost of that warranty is included in the acquisition cost of the item. The cost of any extended warranty is not included in the acquisition cost of the item.

(8) When an item is acquired from a related party, the acquisition cost of the item shall be determined under § 1187.58.

(c) *Offsets to reported cost of movable property.*

(1) If a nursing facility conveys or otherwise transfers movable property acquired during a cost report period beginning on or after January 1, 2001, to any other person as the result of a sale, trade-in, gift, assignment or other transaction, an offset will be made against the nursing facility's allowable movable property costs in the year in which the conveyance or transfer occurs. The amount of the offset will be the greater of the amount paid or credited to the nursing facility for the item by the person to whom the item is conveyed or transferred or the remaining book value of the item on the date the item is conveyed or transferred, as determined based upon the useful life of the item, using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(2) If a nursing facility removes from service an item acquired during a cost report period beginning on or after January 1, 2001, before the expiration of the useful life of the item, determined using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, an offset will be made against the nursing facility's allowable movable property costs in the year in which the item is removed from service. The amount of the offset will be the remaining book value of the item, as determined based upon the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(3) If, for movable property acquired during a cost report period beginning on or after January 1, 2001, a nursing facility receives a refund, money or credit under a lease or rental agreement; or money or credit as a result of a trade-in; or money, including insurance proceeds or damages, as the result of recovery of a loss related to that movable property, the amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(4) If a nursing facility fails to liquidate all or part of the acquisition cost of an item reported on the MA-11 during a cost report period beginning on or after January 1, 2001 in accordance with § 1187.52(b) (relating to allowable cost policies) the unliquidated amount will be offset against the nursing facility's allowable movable property cost in a subsequent fiscal period.

(5) If a nursing facility receives a rebate on an item acquired during a cost report period beginning on or after January 1, 2001, the rebate amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(d) Losses incurred on the sale, transfer or disposal of movable property are not allowable costs

(e) The acquisition cost of movable property that is rented or leased is an allowable cost only if the following requirements are met:

(1) The agreement to rent or lease the movable property shall be in writing, identify each item of movable property that is being rented or leased, identify any other services or supplies that are being provided under the agreement, identify the term of the agreement, the payment intervals, and the amount of the periodic payments and total payments due under the agreement.

(2) The agreement to rent or lease the movable property shall set forth a suggested purchase price for each item of movable property rented or leased.

Subchapter F.
COST REPORTING AND AUDIT REQUIREMENTS

§ 1187.71. Cost reporting.

(a) A nursing facility shall report costs to the MA Program by filing an acceptable MA-11 with the Department. Costs in the MA-11 are:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

(v) Medical director.

(vi) Utilization and medical review.

(vii) Social services.

(viii) Resident activities.

(ix) Volunteer services.

(x) Pharmacy-prescription drugs.

(xi) Over-the-counter drugs.

(xii) Medical supplies.

(xiii) Laboratory and X-rays.

(xiv) Physical, occupational and speech therapy.

(xv) Oxygen.

(xvi) Beauty and barber services.

(xvii) Minor movable property.

(xviii) Other supplies and other resident care costs.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance.

(v) Minor movable property.

(vi) Other supplies and other resident related costs.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility

(vii) Gift shop.

(viii) Advertising.

(ix) Travel/entertainment.

(x) Telephone.

(xi) Insurance.

(xii) Other interest.

(xiii) Legal fees.

(xiv) Federal/State Corporate/Capital Stock Tax.

(xv) Officers' life insurance.

(xvi) Amortization-administrative costs.

(xvii) Office supplies

(xviii) Minor movable property.

(xix) Other supplies and other administrative costs.

(4) *Capital costs.*

(i) Real estate tax cost.

(ii) Major movable property.

(iii) Depreciation.

(iv) Capital interest.

(v) Rent of nursing facility.

(vi) Amortization—capital costs.

(b) The MA-11 shall identify allowable direct, indirect, ancillary, labor and related party costs for the nursing facility and residential or other facility.

(c) The MA-11 shall identify costs of services, movable property and supplies furnished to the nursing facility by a related party and the rental of the nursing facility from a related party.

(d) The MA-11 shall be based on accrual basis financial and statistical records maintained by the nursing facility. The cost information contained in the cost report and in the nursing facility's records shall be current, accurate and in sufficient detail to support the reported costs.

(e) An acceptable cost report is one that meets the following requirements:

(1) Applicable items are fully completed in accordance with the instructions incorporated in the MA-11, including the necessary original signatures on the required number of copies.

(2) Computations carried out on the MA-11 are accurate and consistent with other related computations.

(3) The treatment of costs conforms to the applicable requirements of this chapter.

(4) Required documentation is included.

(5) The MA-11 is filed with the Department within the time limits in § § 1187.73, 1187.75 and 1187.76 (relating to annual reporting; final reporting; and reporting for new nursing facilities).

(f) The nursing facility shall maintain adequate financial records and statistical data for proper determination of costs under the MA Program. The financial records shall include lease agreements, rental agreements, ledgers, books, records and original evidence of cost—purchase requisitions, purchase orders, vouchers, vendor invoices, inventories, time cards, payrolls, bases for apportioning costs and the like—which pertain to the determination of reasonable costs.

(g) Records and other information described in subsection (d) are subject to periodic verification and audit. Costs which are adequately documented are allowable.

(h) The nursing facility shall maintain the records pertaining to each cost report for at least 4 years following the date the nursing facility submits the MA-11 to the Department.

§ 1187.72. Cost reporting for Medicare Part B type services.

(a) Nursing facilities shall utilize Medicare as a primary payor resource when appropriate, under § 1187.102 (relating to utilizing Medicare as a resource).

(b) If Medicare is the primary payor resource, the nursing facility shall exclude from allowable costs operating costs incurred in or income derived from the provision of Medicare Part B coverable services to nursing facility residents. The nursing facility shall attach to the MA-11 a copy of the cost report the nursing facility submits to Medicare for the Part B services and, when available, submit a copy of the Medicare final audit, including audit adjustments.

(c) If there is a discrepancy between the costs on the Medicare cost report or, if available, the Medicare audit report, and the adjustments made by the nursing facility on the MA-11 to exclude Medicare Part B costs, the Department will make the necessary adjustments to conform to the Medicare report.

§ 1187.73. Annual reporting.

(a) The fiscal year, for purposes of the MA Program for nursing facilities, shall be either January 1 through December 31 or July 1 through June 30 as designated by the nursing facility. The fiscal year designated by the nursing facility may not be changed except in the event of the sale of the nursing facility to a new owner.

(b) A nursing facility shall submit an acceptable MA-11 to the Department within 120 days following the June 30 or December 31 close of each fiscal year as designated by the nursing facility. An acceptable MA-11 is one that meets the requirements in § 1187.71(e) (relating to cost reporting). No request for an extension to file an annual cost report will be granted except in accordance with § 1187.1(d)(2) (relating to policy). The report shall be prepared using the accrual basis of accounting and shall cover a fiscal period of 12 consecutive months.

§ 1187.74. Interim reporting.

A nursing facility may not file interim cost reports.

§ 1187.75. Final reporting.

(a) A nursing facility that enters into a termination agreement or an agreement of sale, or is otherwise undergoing a change of ownership or is withdrawing or being terminated as a nursing facility, shall file an acceptable final MA-11 cost report as well as outstanding annual cost reports with the Department within 90 days of the effective date of the termination, transfer, withdrawal or change of ownership and shall provide financial and statistical records to the Department for auditing. An acceptable MA-11 is one that meets the requirements in § 1187.71(e) (relating to cost reporting).

(b) A nursing facility may request an extension to file its final cost reports as required by subsection (a) of up to 30 days from the date the cost reports are due if the nursing facility's request is received by the Department prior to the expiration of the 60th day of the 90-day period specified in subsection (a); the reasons for the extension request and the amount of time requested are specified; and the requirements of § 1187.1(d) (relating to policy) are met. Further extensions will not be granted. The denial of a request for an extension is an adverse action appealable in accordance with § 1187.141 (relating to nursing facility's right to appeal and to a hearing). Failure to appeal a denial within the time period provided precludes any appeal or challenge relating to the denial in another proceeding.

§ 1187.76. Reporting for new nursing facilities.

Nursing facilities beginning operations during a fiscal period shall prepare an MA-11 from the date of certification for participation to the end of the nursing facility's fiscal year.

§ 1187.77. Auditing requirements related to cost report.

(a) The Department will audit acceptable cost reports filed to verify nursing facility compliance with:

(1) This chapter.

(2) Chapter 1101 (relating to general provisions).

(3) The schedules and instructions attached to the MA-11.

(b) A nursing facility shall make financial and statistical records to support the nursing facility's cost reports available to State and Federal representatives upon request.

(c) The Department will conduct audits in accordance with auditing requirements set forth in Federal regulations and generally accepted government auditing standards.

(d) The Department will conduct an audit of each acceptable cost report with an end date of June 30, 1996, or December 31, 1996, and thereafter within 1 year of the Department's acceptance of the cost report. This subsection will not apply if the nursing facility is under investigation by the Attorney General.

(e) The auditor will certify to the Department the allowable cost for the nursing facility to be input into the NIS database for use in determining the median costs.

(f) A nursing facility that has certified financial statements, Medicare intermediary audit reports with adjustments and Medicare reports for the reporting period shall submit these reports with its cost report, at audit or when available.

§ 1187.78. Accountability requirements related to resident personal fund management.

(a) A nursing facility may not require residents to deposit their personal funds with the nursing facility. A nursing facility shall hold, safeguard and account for a resident's personal funds upon written authorization from the resident in accordance with this section and other applicable provisions in State and Federal law.

(b) A resident's personal funds may not be commingled with nursing facility funds or with the funds of a person other than another resident.

(c) A resident's personal funds in excess of $50 shall be maintained in an interest bearing account, and interest earned shall be credited to that account.

(d) A resident's personal funds that do not exceed $50 may be maintained in a noninterest bearing account, interest bearing account or petty cash fund.

(e) Statements regarding a resident's financial record shall be available upon request to the resident or to the resident's legal representative.

(f) The nursing facility shall notify each resident that receives MA benefits when the amount in the resident's personal fund account reaches $200 less than the SSI resource limit for one person.

(g) Within 60 days of the death of a resident, the nursing facility shall convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

(h) The nursing facility may not impose a charge against the personal funds of a resident for an item or service for which payment is made under MA or Medicare.

(i) The nursing facility shall maintain records relating to its management of residents' personal funds for a minimum of 4 years. These records shall be available to Federal and State representatives upon request.

(j) The nursing facility shall purchase a surety bond or otherwise provide assurances of the security of personal funds of the residents deposited with the nursing facility.

§ 1187.79. Auditing requirements related to resident personal fund management.

(a) The Department will periodically audit residents' personal fund accounts.

(b) If discrepancies are found at audit, the nursing facility shall make restitution to the residents for funds improperly handled, accounted for or disbursed. The Department may sanction the nursing facility in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1187.80. Failure to file an MA-11.

(a) Failure by the nursing facility to file a timely MA-11, other than a final MA-11 and annual MA-11s due along with a final MA-11, may result in termination of the nursing facility's provider agreement and will result in adjustment of the nursing facility's per diem rate as provided in this subsection. An MA-11 is considered timely filed if the MA-11 is received within 120 days following the June 30 or December 31 close of each fiscal year as designated by the nursing facility, or if an extension has been granted, within the additional time allowed by the extension. The Department may also seek injunctive relief to require proper filing, as the Department may deem is in the best interest of the efficient and economic administration of the MA program.

(1) *Cost report periods prior to January 1, 2001.*

(i) If an MA-11 is not timely filed, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(2) *Cost report periods beginning January 1, 2001, and thereafter.*

(i) If an MA-11 is not timely filed, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate reduction will begin the first day of the next month and remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate reduction will begin the first day of the next month and remain in effect until an acceptable MA-11 is filed with the Department.

(b) If a nursing facility fails to file a timely final MA-11 and outstanding annual MA-11s:

(1) The net operating components of the nursing facility's per diem rate will be determined on the basis of the nursing facility's peer group medians, prior to the percent of median adjustment in accordance with § 1187.96 (relating to price and rate setting computations), for the last fiscal period for which the nursing facility has an acceptable MA-11 on file.

(2) The capital component of the nursing facility's per diem rate will be set at $0.

Subchapter G. RATE SETTING

§ 1187.91. Database.

The Department will set rates for the case-mix payment system based on the following data:

(1) *Net operating costs*.

(i) The net operating prices will be established based on the following:

(A) Audited nursing facility costs for the 3 most recent years available in the NIS database adjusted for inflation. This database includes audited MA-11 cost reports that are issued by the Department on or before March 31 of each July 1 price setting period.

(B) If a nursing facility that has participated in the MA Program for 3 or more consecutive years has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use reported costs, as adjusted to conform to Department regulations, for those years not audited within 15 months of the date of acceptance, until audits have been completed and are available in the NIS database for price setting.

(C) If a nursing facility, that has not participated in the MA Program for 3 or more consecutive years, has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use all available audited cost reports in the NIS database.

(D) For net operating prices effective on or after July 1, 2001, the Department will revise the audited costs specified in clauses (A)—(C) by disregarding audit adjustments disallowing or reclassifying to capital costs, the costs of minor movable property (as defined in § 1187.2 (relating to definitions), effective on July 1, 2001) or linens reported as net operating costs on cost reports for fiscal periods beginning prior to January 1, 2001. The Department will not adjust the audited statistics when revising the nursing facility audited resident care, other resident care and administrative allowable costs to disregard the adjustments relating to minor movable property and linen costs. After revising the audited costs to disregard these adjustments, the Department will recalculate the maximum allowable administrative cost, and will disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i) (relating to selected administrative cost policies).

(ii) Subparagraph (i)(B) does not apply if a nursing facility is under investigation by the Office of Attorney General. In this situation, the Department will use a maximum of the three most recent available audited cost reports in the NIS database used for price setting.

(iii) A cost report for a period of less than 12 months will not be included in the NIS database used for each price setting year.

(iv) Prior to price setting, cost report information will be indexed forward to the 6th month of the 12-month period for which the prices are set. The index used is the 1st Quarter issue of the CMS Nursing Home Without Capital Market Basket Index.

(v) Total facility and MA CMI averages from the quarterly CMI reports will be used to determine case-mix adjustments for each price-setting and rate-setting period as specified in § 1187.96(a)(1)(i) and (5) (relating to price- and rate-setting computations).

(2) *Capital costs*.

(i) *Fixed property component*. The fixed property component of a nursing facility's capital rate will be based upon the total assigned cost of the nursing facility's allowable beds.

(ii) *Movable property component*. The movable property component of a nursing facility's capital rate will be based upon the audited costs of the nursing facility's major movable property as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

(A) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1 ,2001, the movable property component of a nursing facility's capital rate will be based upon the fair rental value of the nursing facility's major and minor movable property.

(B) When the nursing facility's most recent audited MA-1'1 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001 , the movable property component of a nursing facility's capital rate will be based upon the audited costs of the nursing facility's major movable properly as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database

(iii) *Real estate tax cost component*. The real estate tax component of a nursing facility's capital rate will be based upon the nursing facility's actual audited real estate tax costs as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

§ 1187.92. Resident classification system.

(a) The Department will use the RUG-III to adjust payment for resident care services based on the classification of nursing facility residents into 44 groups.

(b) Each resident shall be included in the RUG-III category with the highest numeric CMI for which the resident qualifies.

(c) The Department will use the RUG-III nursing CMI scores normalized across all this Commonwealth's nursing facility residents.

(d) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix A, the RUG-III nursing CMI scores and the PA normalized RUG-III index scores.

(e) The PA normalized RUG-III index scores will remain in effect until a subsequent notice is published in the *Pennsylvania Bulletin*.

(f) Resident data for RUG-III classification purposes shall be reported by each nursing facility under § 1187.33 (relating to resident data reporting requirements).

§ 1187.93. CMI calculations.

The Pennsylvania Case-Mix Payment System uses the following CMI calculations:

(1) An individual resident's CMI shall be assigned to the resident according to the RUG-III classification system.

(2) The facility MA CMI shall be the arithmetic mean of the individual CMIs for MA residents identified on the nursing facility's CMI report for the picture date. The facility MA CMI shall be used for rate determination under § 1187.96(a)(5) (relating to price and rate-setting computations.) If there are no MA residents identified on the CMI report for a picture date, the Statewide average MA CMI shall be substituted for rate determination under § 1187.96(a)(5).

(3) The total facility CMI is the arithmetic mean of the individual resident CMIs for all residents, regardless of payor, identified on the nursing facility's CMI report for the picture date. The total facility CMI for the February 1 picture date shall be used for price and rate setting computations as specified in § 1187.96(a)(1)(i).

§ 1187.94. Peer grouping for price setting.

To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program into 14 mutually exclusive groups as follows:

(1) Nursing facilities participating in the MA Program, except those nursing facilities that meet the definition of a special rehabilitation facility or hospital-based nursing facility, will be classified into 12 mutually exclusive groups based on MSA group classification and nursing facility certified bed complement.

(i) Effective for rate setting periods commencing July 1, 2004, the Department will use the MSA group classification published by the Federal Office of Management and Budget in the OMB Bulletin No. 99-04 (relating to revised definitions of Metropolitan Areas and guidance on uses of Metropolitan Area definitions), to classify each nursing facility into one of three MSA groups or one non-MSA group.

(ii) The Department will use the bed complement of the nursing facility on the final day of the reporting period of the most recent audited MA-11 used in the NIS database to classify nursing facilities into one of three bed complement groups.

(iii) The Department will classify each nursing facility into one of the following 12 peer groups:

Peer Group #	*MSA Group*	*# Beds*
1	A	› or = 270
2	A	120—269
3	A	3—119
4	B	› or = 270
5	B	120—269
6	B	3—119
7	C	› or = 270
8	C	120—269
9	C	3—119
10	non-MSA	› or = 270
11	non-MSA	120—269
12	non-MSA	3—119

(iv) A peer group with fewer than seven nursing facilities will be collapsed into the adjacent peer group with the same bed size. If the peer group with fewer than seven nursing facilities is a peer group in MSA B or MSA C and there is a choice of two peer groups with which to merge, the peer group with fewer than seven nursing facilities will be collapsed into the peer group with the larger population MSA group.

(v) For rate years 2009-2010, 2010-2011 and 2011-2012, county nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with subparagraph (iv).

(2) To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program that meet the definition of a special rehabilitation facility into one peer group, peer group number 13. Regardless of the number of facilities in this peer group, the Department will not collapse the peer group of special rehabilitation facilities.

(i) Effective November 1, 2011, the Department will establish peer group medians and prices for facilities classified as special rehabilitation facilities on or before July 1, 2000, by using data from only the nursing facilities classified as special rehabilitation facilities on or before July 1, 2000.

(ii) Effective November 1, 2011, the Department will establish peer group medians and prices for facilities classified as special rehabilitation facilities after July 1, 2000, by using data from all nursing facilities classified as special rehabilitation facilities.

(3) To set net operating prices under the case-mix payment system, the Department will classify the nursing facilities participating in the MA Program that meet the definition of a hospital-based nursing facility into one peer group, peer group number 14. Regardless of the number of facilities in this peer group, the Department will not collapse the peer group of hospital-based nursing facilities.

(4) Once nursing facilities have been classified into peer groups for price setting, the nursing facility costs will remain in that peer group until prices are rebased, unless paragraph (5) applies.

(5) Paragraph (3) sunsets on the date that amendments are effective in Chapter 1163 (relating to inpatient hospital services), to allow for the inclusion of costs previously allocated to hospital-based nursing facilities. Subsequent to the effective date of the amendments to Chapter 1163, the Department will classify hospital-based nursing facilities in accordance with paragraph (1).

§ 1187.95. General principles for rate and price setting.

(a) Prices will be set prospectively on an annual basis during the second quarter of each calendar year and be in effect for the subsequent July 1 through June 30 period.

(1) Peer group prices will be established for resident care costs, other resident related costs and administrative costs.

(2) If a peer group has an even number of nursing facilities, the median peer group price determined will be the arithmetic mean of the costs of the two nursing facilities holding the middle position in the peer group array.

(3) If a nursing facility changes bed size or MSA group, the nursing facility will be reassigned from the peer group used for price setting to peer group based on bed certification and MSA group as of April 1, for rate setting.

(4) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix B, the peer group prices for each peer group.

(b) Rates will be set prospectively each quarter of the calendar year and will be in effect for 1 full quarter. Net operating rates will be based on peer group prices as limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers). The nursing facility per diem rate will be computed as defined in § 1187.96(e) (relating to price- and rate-setting computations). Resident care peer group prices will be adjusted for the MA CMI of the nursing facility each quarter and be effective on the first day of the following calendar quarter.

Resident care peer group prices will be adjusted for the MA CMI of the nursing facility each quarter and be effective on the first day of the following calendar quarter.

§ 1187.96. Price- and rate-setting computations.

(a) Using the NIS database in accordance with this subsection and § 1187.91 (relating to database), the Department will set prices for the resident care cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total resident care cost for each cost report will be divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year.

(ii) The case-mix neutral total resident care cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the case-mix neutral resident care cost per diem for the cost report year.

(iii) The Department will calculate the 3-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

(2) The average case-mix neutral resident care cost per diem for each nursing facility will be arrayed within the respective peer groups, and a median determined for each peer group.

(3) For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price will be the phase-out median as determined in accordance with § 1187.98 (relating to phase-out median determination).

(4) The median of each peer group will be multiplied by 1.17, and the resultant peer group price assigned to each nursing facility in the peer group.

(5) The price derived in paragraph (4) for each nursing facility will be limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers) and the amount will be multiplied each quarter by the respective nursing facility MA CMI to determine the nursing facility resident care rate. The MA CMI picture date data used in the rate determination are as follows: July 1 rate—February 1 picture date; October 1 rate—May 1 picture date; January 1 rate—August 1 picture date; and April 1 rate—November 1 picture date.

(6) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the resident care rate used to establish the nursing facility's case-mix per diem rate will be a blended resident care rate.

(i) The nursing facility's blended resident care rate for the 2010-2011 rate year will equal 75% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (iv) plus 25% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (iv).

(ii) The Department will calculate the 3-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

(2) The average other resident related cost per diem for each nursing facility will be arrayed within the respective peer groups and a median determined for each peer group.

(3) For rate years 2006-2007 and 2007-2008 the median used to set the other resident related price will be the phase-out median as determined in accordance with §1187.98.

(4) The median of each peer group will be multiplied by 1.12, and the resultant peer group price assigned to each nursing facility in the peer group. This price for each nursing facility will be limited by § 1187.107 to determine the nursing facility other resident related rate.

(c) Using the NIS database in accordance with this subsection and §1187.91, the Department will set prices for the administrative cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total actual resident days for each cost report will be adjusted to a minimum 90% occupancy, if applicable, in accordance with §1187.23 (relating to nursing facility incentives and adjustments.

(ii) The total allowable administrative cost for each cost report will be divided by the total actual resident days, adjusted to 90% occupancy, if applicable, to obtain the administrative cost per diem for the cost report year.

(iii) The Department will calculate the 3-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

(2) The average administrative cost per diem for each nursing facility will be arrayed within the respective peer groups and a median determined for each peer group.

(3) For rate years 2006-2007 and 2007-2008 the median used to set the administrative price will be the phase-out median as determined in accordance with §1187.98.

(4) The median of each peer group will be multiplied by 1.04, and the resultant peer group price will be assigned to each nursing facility in the peer group to determine the nursing facility's administrative rate.

(d) Using the NIS database in accordance with this subsection and §1187.91 , the Department will set a rate for the capital cost category for each nursing facility by adding the nursing facility's fixed property component, movable property component and real estate tax component and dividing the sum of the three components by the nursing facility's total actual resident days, adjusted to g0% occupancy, if applicable.

(1) The Department will determine the fixed property component of each nursing facility's capital rate as follows:

(i) The Department will adjust the appraised depreciated replacement cost of the nursing facility's fixed property to account for the per bed limitation in §1187.112 (relating to cost per bed limitation adjustment) and the bed moratorium addressed in §1187.13 (relating to capital component payment limitation).

(ii) The Department will multiply the adjusted depreciated replacement costs of the fixed property by the financial yield rate to determine the fair rental value for the nursing facility's fixed property.

(iii) The nursing facility's fixed properly component will equal the fair rental value of its fixed property.

(2) The Department will determine the movable property component of each nursing facility's capital rate as follows:

(i) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001:

(A) The Department will multiply the depreciated replacement costs of the movable property by the financial yield rate to determine the fair rental value for the nursing facility's movable property.

(B) The nursing facility's movable property component will equal the fair rental value of its movable property.

(ii) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001 the amount of the movable property component will be based upon the audited actual costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database. This amount is referred to as the nursing facility's most recent movable property cost.

(3) The Department will determine the real estate tax cost component of each nursing facility's capital rate based on the audited actual real estate tax cost as set forth in the most recent audited MA-'l 1cost report available in the NIS database.

(e) The following applies to the computation of nursing facilities' per diem rates:

(1) The nursing facility per diem rate will be computed by adding, the resident care rate, the other resident related rate, the administrative rate and the Capital rate for the nursing facility.

(2) Foreach quarter of the 2006-2007 and 2007-2008 rate setting years, the nursing facility per diem rate will be computed as follows:

(i) Generally. If a nursing facility is not a new nursing facility or a nursing facility . experiencing a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with subsections (a) - (O) and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(ii) New nursing facilities. If a nursing facility is a new nursing facility for purposes of § 1187.97(1) (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities) that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with S 1187.9(1), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iii) Nursing facilities with a change of ownership and reorganized nursing facilities. If a nursing facility undergoes a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(2) and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iv) Budget adjustment factor. The budget adjustment factor for the rate year will be determined in accordance with the formula set forth in the Commonwealth's approved State Plan.

§ 1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities.

The Department will establish rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities as follows:

(1) *New nursing facilities.*

(i) The net operating portion of the case-mix rate is determined as follows:

(A) A new nursing facility, unless a former county nursing facility, will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under § 1187.33 (relating to resident data and picture date reporting requirements) is used in a rate determination under § 1187.96(a)(5) (relating to price- and rate-setting computations).

(B) For a former county nursing facility, the county nursing facility's assessment data and MA CMI will be transferred to the new nursing facility.

(C) The nursing facility will be assigned to the appropriate peer group. The peer group price for resident care, other related and administrative costs will be assigned to the nursing facility until there is at least one audited nursing facility cost report used in the rebasing process.

(ii) For nursing facilities enrolled in the MA Program prior to January 1, 2001, the three components of the capital portion of the case-mix rate are determined as follows:

(A) The fixed property component will be determined in accordance with § 1187.96 (d)(1) (relating to price and rate setting computations).

(B) The movable property component will be determined in accordance with § 1187.96 (d)(2).

(C) The real estate tax cost component will be determined based on the audited actual real estate tax cost. (iii) For nursing facilities enrolled in the MA Program on or after January 1,2001, the three components of the capital portion of the case-mix rate are determined as follows:

(A). Fixed property component The fixed property component will be determined in accordance with § 1187.96(d)(1).

(B) Movable property component. The movable property component will be determined as follows:

(l) The nursing facility's acquisition cost, as determined in accordance with § 1157.61(b) (relating to movable property cost policies), for any new items of movable property acquired on or before the date of enrollment in the MA program, will be added to the nursing facility's remaining book value for any used movable property as of the date of enrollment in the MA program to arrive at the nursing facility's movable property cost. If the nursing facilities not have a depreciation schedule for its used movable property, the allowable cost for those items will be the depreciated replacement cost as determined by qualified personnel of the Department's independent appraisal contractor.

(ll) The nursing facility's movable property cost will then be amortized equally over the first 3 rate years that the nursing facility is enrolled in the MA program to determine the nursing facility's movable property component of the capital rate.

(lll) After the first 3 rate years the nursing facility's movable property component will ' be based on the most recent audited MA-11 cost report available in the NIS database. If no MA-11 is available in the NIS database, the nursing facility will not receive the movable property component of the capital rate.

(C) Real estate tax component.

(l) For the first 3 rate years, the new nursing facility real estate tax component will be the nursing facility's annual real estate tax cost as of the date of enrollment in the MA program.

(ll) After the first 3 rate years, the real estate tax component will be based on the audited MA-11 cost report available in the NIS database. If no audited MA'11 cost report is available in the NIS database, the nursing facility will not receive the real estate tax component of the capital rate.

(iv) Newly constructed nursing facilities are exempt from the adjustment to 90% occupancy until the nursing facility has participated in the MA Program for one full annual price setting period as described in § 1187.95 (relating to general principles for rate and price setting).

(2) *Nursing facilities with a change of ownership and reorganized nursing facilities.*

(i) *New provider*. The new nursing facility provider will be paid exactly as the old nursing facility provider, except that, if a county nursing facility becomes a nursing facility between July 1, 2006 and June 30 2008, the per diem rate for the nursing facility will be computed in accordance with S 1187.96, using the data contained in the NIS database. Net operating and capital rates for the old nursing facility provider will be assigned to the new nursing facility provider.

(ii) *Transfer of data*. Resident assessment data will be transferred from the old nursing facility provider number to the new nursing facility provider number. The old nursing facility's MA CMI will be transferred to the new nursing facility provider.

(iii) *Movable property cost policies.*

(A) The acquisition costs of items acquired by the old nursing facility provider on or before the date of sale are costs of the old nursing facility provider, and not the new nursing facility provider.

(B) Regardless of the provisions of any contract of sale, the amount paid by the new nursing facility provider to acquire or obtain any rights to items in the possession of the old nursing facility provider is not an allowable cost.

(C) If the new nursing facility provider purchases an item from the old nursing facility provider, the cost of that item is not an allowable cost for cost reporting or rate setting purposes.

(D) If the new nursing facility provider rents or leases an item from the old nursing facility provider, the cost of renting or leasing that item is not an allowable cost for cost reporting or rate setting purposes.

(3) Former prospective payment nursing facilities. A nursing facility that received a prospective rate prior to the implementation of the case-mix payment system will be treated as a new nursing facility under paragraph (1) for the purpose of establishing a per diem rate.

§ 1187.98. Phase-out median determination.

For rate years 2006-2007 and 2007-2008, the Department will determine a phase-out median for each net operating cost center for each peer group to calculate a peer group price. The Department will establish the phase-out median as follows:

(1) Peer groups will be established in accordance with § § 1187.91 and 1187.94 (relating to database; and peer grouping for price setting).

(2) County nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv).

(3) Audited county nursing facilities' costs from the 3 most recent audited cost reports audited in accordance with this chapter, will be included in the established peer groups when determining a median in accordance with § 1187.96 (relating to price- and rate-setting computations).

Subchapter H. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1187.101. General payment policy.

(a) Payment for nursing facility services will be subject to the following conditions and limitations:

(1) This chapter and Chapter 1101 (relating to general provisions).

(2) Applicable State statutes.

(3) Applicable Federal statutes and regulations and the Commonwealth's approved State Plan.

(b) Payment will not be made for nursing facility services at the MA per diem rate if full payment is available from another public agency, another insurance or health program or the resident's resources.

(c) Payment will not be made in whole or in part for nursing facility services provided during a period in which the nursing facility's participation in the MA Program is terminated.

(d) Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101. In addition, the Department will perform the reviews specified in this chapter for controlling the utilization of nursing facility services.

§ 1187.102. Utilizing Medicare as a resource.

(a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified nursing facility and is authorized by the Medicare Program to receive nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the nursing facility's MA per diem rate for nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the nursing facility. The Department will not pay more than the maximum coinsurance amount.

(b) If a resident has Medicare Part B coverage, the nursing facility shall use available Medicare Part B resources for Medicare Part B services before payment is made by the MA Program.

(c) The nursing facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible resident because of the limit of the nursing facility's MA per diem rate.

(d) The Department will recognize the Medicare payment as payment in full for each day that a Medicare payment is made during the Medicare-only benefit period.

(e) The cost of providing Medicare Part B type services to MA recipients not eligible for Medicare Part B services which are otherwise allowable costs under this part are reported in accordance with § 1187.72 (relating to cost reporting for Medicare Part B type services).

§ 1187.103. Cost finding and allocation of costs.

(a) A nursing facility shall use the direct allocation method of cost finding. The costs will be apportioned directly to the nursing facility and residential or other facility, based on appropriate financial and statistical data.

(b) Allowable operating cost for nursing facilities will be determined subject to this chapter and the *Medicare Provider Reimbursement Manual*, CMS Pub. 15-1, except that if this chapter and CMS Pub. 15-1 differ, this chapter applies.

§ 1187.104. Limitations on payment for reserved beds.

The Department will make payment to a nursing facility for a reserved bed when the resident is absent from the nursing facility for a continuous 24-hour period because of hospitalization or . therapeutic leave. A nursing facility shall record each reserved bed for therapeutic leave on the nursing facility's daily census record and MA invoice. When the bed reserved for a resident who is hospitalized temporarily occupied by another resident, a nursing facility shall record the occupied bed on the nursing facility's daily MA census record and the MA invoice. During the reserved bed period the same bed shall be available for the resident upon the resident's return to the nursing facility. The following limits on payment for reserved bed days apply:

(1) *Hospitalization.*

(i) A resident receiving nursing facility services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will pay a nursing facility at a rate of 1/3 of the nursing facility's current per diem rate on file with the Department for a hospital reserved bed day.

(ii) If the resident's hospital stay exceeds the Department's 15 reserved bed days payment limitation, the nursing facility shall readmit the resident to the nursing facility upon the first availability of a bed in the nursing facility if, at the time of readmission, the resident requires the services provided by the nursing facility.

(iii) Hospital reserved bed days may not be billed as therapeutic leave days.

(2) Therapeutic leave. A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the nursing facility if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a nursing facility the nursing facility's current per diem rate on file with the Department for a therapeutic leave day.

§ 1187.105. Limitations on payment for prescription drugs.

The Department's per diem rate for nursing facility services does not include prescription drugs. Prescribed drugs for the categorically needy and medically needy are reimbursable directly to a licensed pharmacy in accordance with Chapter 1121 (relating to pharmaceutical services).

§ 1187.106. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents is certifiable and licensed to provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring nursing facility provider number as long as the transferring nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§ 1187.107. Limitations on resident care and other resident related cost centers.

(a) The Department will set a limit on the resident care peer group price for each nursing facility for each year, using the NIS database as specified in § 1187.91 (relating to database), to the lower of:

(1) The nursing facility resident care peer group price.

(2) One hundred three percent of the nursing facility's average case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility resident care peer group price.

(b) The Department will set a limit on the other resident related peer group price for each nursing facility for each base year, using the NIS database as specified in § 1187.91 to the lower of:

(1) The nursing facility other resident related peer group price.

(2) One hundred three percent of the nursing facility average other resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility other resident related peer group price.

§ 1187.108. Gross adjustments to nursing facility payments.

(a) The case-mix payment system is a prospective system. There is no cost settlement under the case-mix payment system.

(b) Certain adjustments may be made which increase or decrease the payment which a nursing facility may have otherwise received. Gross adjustments to nursing facility payments are based on one or more of the following general provisions:

(1) If audit findings result in changing the peer group median and the peer group price, a retrospective gross adjustment is made for each nursing facility in the peer group where the change occurred.

(2) If a nursing facility's MA CMI changes as a result of UMR resident assessment audit adjustments, retrospective gross adjustments shall be made for the nursing facility involved.

(c) Specific adjustments of the gross payments received by a nursing facility may be required by § § 1187.109—1187.115.

§ 1187.109. Medicare upper limit on payment.

Nursing facilities shall submit Medicare information on the MA-11. MA payments will not exceed in the aggregate the comparable amount that Medicare would have paid had the Medicare Program reimbursed for the services rendered.

§ 1187.110. Private pay rate adjustment.

The MA rate is limited by the nursing facility's private pay rate for the comparable rate period.

§ 1187.111. Disproportionate share incentive payments.

(a) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(1) The nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(2) The nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(b) The disproportionate share incentive payments will be based on the following for year 1 of implementation:

	Overall Occupancy	*MA Occupancy (y)*	*Per Diem Incentive*
Group A	90%	›= 90% y	$2.50
Group B	90%	88%‹= y ‹90%	$1.70
Group C	90%	86%‹= y ‹88%	$1.00
Group D	90%	84%‹= y ‹86%	$0.60
Group E	90%	82%‹= y ‹84%	$0.30
Group F	90%	80%‹= y ‹82%	$0.20

(c) For each year subsequent to year 1 of implementation, disproportionate share incentive payments as described in subsection (b) will be inflated forward using the Health Care Financing Administration Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(d) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before 210 days of the close of the nursing facility fiscal year.

(e) For the period July 1, 2005, to June 30, 2009, the disproportionate share incentive payment to qualified nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with subsection (c).

(1) For the period commencing July 1, 2005, through June 30, 2006, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2005, or June 30, 2006.

(2) For the period commencing July 1, 2006, through June 30, 2007, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2006, or June 30, 2007.

(3) For the period commencing July 1, 2007, through June 30, 2008, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2007, or June 30, 2008.

(4) For the period commencing July 1, 2008, through June 30, 2009, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2008, or June 30, 2009.

§ 1187.111. Cost per bed limitation adjustment.

(a) For year 1 of implementation the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $22,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be ,included in the $22,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $22,000 per bed limitation will be made. The full appraisal value will not be recognized.

(b) For year 2 of implementation ad year 3 of implementation ad thereafter the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $26,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be included in the $26,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $26,000 per bed limitation will be made. The full appraisal value will not be recognized.

§ 1187.113. Capital component payment limitation.

(a) *Conditions.* The capital component payment for fixed property is subject to the following conditions:

(1) The Department will make the capital component payment for fixed property on new or additional beds only if one of the following applies:

(i) The nursing facility was issued either a Section 1122 approval or letter of non-reviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of non-reviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health by August 31, 1982.

(ii) The nursing facility was issued a Certificate of Need or letter of non-reviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility located within the county.

(2) The Department will not make the capital component payment unless the nursing facility substantially implements the project under 28 Pa. Code Chapter 401 within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) The capital component payment for replacement beds is allowed only if the nursing facility was issued a Certificate of Need or a letter of non-reviewability for the project by the Department of Health.

(4) The Department will not make the capital component payment unless written approval was received from the Department prior to the construction of the new beds.

(b) *Capital cost reimbursement waivers.* The Department may grant waivers of subsection (a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department will publish a statement of policy under § 9.12 (relating to statements of policy) specifying the criteria that it will apply to evaluate and approve applications for capital cost reimbursement waivers.

§ 1187.113a. Nursing facility replacement beds—statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for replacement beds constructed, licensed or certified after November 29, 1997.

(b) *Purpose.*

(1) Department regulations relating to capital component payments for nursing facilities enrolled and participating in the Commonwealth's Medical Assistance (MA) Program state that capital component payments for replacement beds are allowed only if the nursing facility was ''issued a Certificate of Need or a letter of non-reviewability for the project by the Department of Health.'' See § 1187.113(a)(3) (relating to capital component payment limitations).

(2) Chapter 7 and all other portions of the Health Care Facilities Act (35 P. S. § § 448.701—448.712) pertaining to Certificates of Need (CON) sunsetted on December 18, 1996. To allow the Department to continue to make capital component payments for replacement beds for which a nursing facility does not have a CON or letter of non-reviewability, the Department will amend its regulations to specify the conditions under which it will recognize beds as replacement beds for purposes of making capital component payments. Pending the promulgation of these regulations, the Department has issued this section to specify instances in which the Department will make capital component payments for replacement beds.

(c) *Requests for approval of replacement beds.* A nursing facility provider that intends to seek capital component payments under § 1187.113(a)(3) for nursing facility beds constructed, licensed or certified after November 29, 1997, shall submit a written request to the Department for approval of the beds as replacement beds.

(1) The facility shall submit an original and two copies of its request prior to beginning construction of the beds. If a facility began construction of the beds prior to November 29, 1997, the facility shall submit an original and two copies of its request by February 27, 1998, or the date on which the facility requested the Department of Health to issue a license for the beds, whichever date is earlier.

(2) A facility that fails to submit a request under paragraph (1) may not receive capital component payments for the beds.

(d) *Policy regarding approval of replacement beds.*

(1) *Nursing facility beds authorized under a CON dated on or before December 18, 1996.*

(i) The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if the following conditions are met:

(A) The facility has a CON or letter of nonreviewability dated on or before December 18, 1996, authorizing the replacement bed project.

(B) The facility has ‘‘substantially implemented’’ its project, as defined in 28 Pa. Code § 401.2 (relating to definitions).

(C) The beds that are being replaced:

(I) Are currently certified.

(II) Are premoratorium beds.

(III) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(ii) If a facility has a CON dated on or before December 18, 1996 authorizing a replacement bed project, but the facility fails to substantially implement its project as defined in 28 Pa. Code § 401.2, the Department will treat the facility as though it does not have a CON, and consider the facility’s request under paragraph (2).

(2) *Nursing facility beds not authorized by a CON dated on or before December 18, 1996.* The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if, after applying the guidelines set forth in subsection (e), the Department determines that the following conditions are met:

(i) Construction of the replacement beds is necessary to assure that MA recipients have access to nursing facility services consistent with applicable law. If the Department determines that some, but not all, of the replacement beds are necessary to assure that MA recipients have appropriate access to nursing facility services, the Department may limit its approval to the number of beds it determines are necessary. If the Department limits its approval to some of the beds, the remaining unapproved beds will not qualify for capital component payments.

(ii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be constructed within a 1-mile radius of the existing structure in which the beds that are being replaced are situated.

(iii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be attached or immediately adjacent to the existing structure in which beds that are being replaced are situated if the replacement beds will replace only a portion of the beds in the existing structure.

(iv) The beds that are being replaced:

(A) Are currently certified.

(B) Are premoratorium beds.

(C) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(e) *Guidelines for evaluation of requests to construct replacement beds.* The Department will use the following guidelines, and will consider the following information, as relevant in determining whether to approve replacement beds under subsection (d)(2).

(1) Whether, and to what extent, construction of all the replacement beds is required to ensure the health, safety and welfare of the residents of the facility.

(2) Whether, and to what extent, building code violations or other regulatory violations exist at the facility requiring the construction of all of the replacement beds. If the provider alleges these violations, it shall attach waivers from the relevant regulatory agencies, and explain why the waivers of code violations may not continue indefinitely.

(3) Whether, and to what extent, the facility has considered the development of home and community-based services in lieu of replacing some or all of its beds.

(4) Whether other support services for MA recipients, including home and community-based services, are available in lieu of nursing facility services.

(5) Whether the overall total occupancy and MA occupancy levels of the facility and facilities in the county indicate that there is a need for all or a portion of the replacement beds.

(6) If the provider is proposing to construct a new facility or wing, whether the provider has satisfactorily demonstrated that it would be more costly to renovate the provider's current facility rather than to construct the new facility or wing.

(7) Whether the facility, or section of the facility, which currently contains the beds to be replaced is able to be utilized for another purpose.

(f) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Premoratorium beds—Nursing facility beds that were built under an approved CON dated on or before August 31, 1982, and for which the Department is making a capital component payment under these regulations.

Replacement beds—Nursing facility beds constructed in a new building or structure that take the place of existing beds located in a separate or attached building or structure; or reconstructed or renovated beds within an existing building or structure when the cost of the reconstruction or renovation equals or exceeds 50% of the total facility's appraised value in effect for the rate period in which the request is made.

§ 1187.113b. Capital cost reimbursement waivers—statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for existing postmoratorium beds in a nursing facility. This section also applies to participating providers who were granted moratorium waivers under Chapter 1181 (relating to nursing facility care).

(b) *Purpose.* The purpose of this section is to announce the criteria that the Department will apply to evaluate and approve applications for capital cost reimbursement waivers of § 1187.113(a) (relating to capital component payment limitation) and to reaffirm that nursing facilities that were granted waivers under Chapter 1181 continue to receive capital component payments under this chapter. Waivers of § 1187.113(a) will not otherwise be granted except as provided in this section.

(c) *Submission and content of applications.*

(1) An applicant seeking a waiver of § 1187.113(a) shall submit a written application and two copies to the Department at the following address:

Department of Public Welfare
Bureau of Long Term Care Programs
P. O. Box 2675
Harrisburg, PA 17105-2675
ATTN: MORATORIUM WAIVER REVIEW

(2) The written application shall address the criteria in subsections (d) and (e). If necessary, the application should include supporting documentation.

(d) *Policy regarding additional capital reimbursement waivers.* Section 1187.113(b) authorizes the Department to grant waivers of § 1187.113(a) to permit capital reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department has determined that a waiver of § 1187.113(a) will only be necessary and appropriate when the Secretary or a designee finds that the waiver is in the Department's best interests and will serve to promote the Commonwealth's policy to encourage the growth of home and community-based services available to MA recipients.

(1) The Department will find that a waiver serves to promote the Commonwealth's policy to encourage the growth of MA home and community-based services only if the Department concludes that the following criteria are met:

(i) The application for a waiver is made by or on behalf of a person who has been the legal entity of two MA participating nursing facilities that meet the following conditions:

(A) Have both been owned by the legal entity for at least 3 consecutive years prior to the date of application.

(B) Serve residents from the same primary service area.

(C) Have each maintained an average MA occupancy rate that exceeds the Statewide MA occupancy rate for 3 consecutive years prior to the date of the application.

(D) Are identified in the application.

(ii) The applicant agrees to permanently decertify all beds in and close one of the two nursing facilities identified in its application in consideration of obtaining a waiver to permit capital component payments to the remaining nursing facility identified in the application.

(iii) Closing the nursing facility will not create an access to care problem for day-one MA eligible recipients in the nursing facility's primary service area.

(iv) One or more of the beds decertified as a result of the closing of the nursing facility is a premoratorium bed.

(v) The legal entity is willing and able to transfer all residents that are displaced by the closing of the nursing facility to the legal entity's remaining nursing facility, unless the residents choose and are able to be transferred elsewhere.

(vi) The remaining nursing facility has one or more existing postmoratorium beds.

(vii) The applicant agrees that, as a condition of both obtaining and receiving continuing payment pursuant to the waiver, the remaining nursing facility will achieve and maintain an MA occupancy rate equal to or greater than the county average MA occupancy rate or the combined average MA occupancy rate (over the past 3 years) of the closed nursing facility and the remaining nursing facility, whichever is higher.

(viii) The applicant agrees that, if the waiver is granted, it will notify the Department in writing at least 90 days prior to the sale, transfer or assignment of a 5% or more ownership interest, as defined in section 1124(a)(3) of the Social Security Act (42 U.S.C.A. § 1320a-3(a)(3)), in the remaining nursing facility.

(ix) The legal entity is not disqualified from receiving a waiver under subsection (e).

(x) The applicant agrees that the waiver is subject to revocation under the conditions specified in subsection (f).

(xi) The applicant agrees that the Bureau of Hearings and Appeals affords an adequate, and appropriate forum in which to resolve disputes and claims with respect to the remaining nursing facility's participation in, and payment under, the MA Program, including claims or disputes arising under the applicant's provider agreement or addendum thereto, and that, in accordance with applicable provisions of 2 Pa.C.S. § § 501—508 and 701—704 (relating to administrative agency law) and § § 1101.84 and 1187.141 (relating to provider right of appeal; and missing facility's right to appeal and to a hearing), the applicant will litigate claims pertaining to its remaining facility exclusively in the Bureau of Hearings and Appeals, subject to its right to seek appellate judicial review.

(xii) The applicant agrees that it will not challenge the Department's denial of capital component payments to postmoratorium beds in the remaining nursing facility.

(xiii) The MA Program will experience overall cost savings if the waiver is granted.

(xiv) The proposal is otherwise in the best interests of the Department. In determining whether the proposal is in its best interests, the Department may consider the following:

(A) Whether the legal entity has demonstrated a commitment to serve MA recipients. In making this determination, the Department will consider the MA occupancy rate of all nursing facilities related by ownership or control to the legal entity.

(B) Whether the legal entity has demonstrated a commitment to provide and develop alternatives to nursing facility services, such as home and community-based services.

(C) Whether the legal entity is willing to refer all persons (including private pay applicants) who seek admission to the remaining nursing facility to the Department or an independent assessor for pre-admission screening, and to agree to admit only those persons who are determined by that screening to be clinically eligible for nursing facility care.

(D) Other information that the Department deems relevant.

(2) If the Department concludes that the criteria specified in paragraph (1) have been met, the Department will grant a waiver to permit capital component payments to the remaining nursing facility. Capital component payments made pursuant to the waiver shall be limited to the number of postmoratorium beds in the remaining nursing facility as of the date the waiver is granted, or the number of premoratorium beds decertified as a result of the closure of the other nursing facility, whichever number is less.

(e) *Disqualification for past history of serious program deficiencies.* The Department will not grant a waiver of § 1187.113(a) if:

(1) The legal entity, any owner of the legal entity or the nursing facility is currently precluded from participating in the Medicare Program or any state Medicaid Program.

(2) The legal entity or any owner of the legal entity, owned, operated or managed a nursing facility at any time during the 3-year period prior to the date of the application and one of the following applies:

(i) The nursing facility was precluded from participating in the Medicare Program or any state Medicaid Program.

(ii) The nursing facility had its license to operate revoked or suspended.

(iii) The nursing facility was subject to the imposition of sanctions or remedies for residents' rights violations.

(iv) The nursing facility was subject to the imposition of remedies based on the failure to meet applicable Medicare and Medicaid Program participation requirements, and the nursing facility's deficiencies immediately jeopardized the health and safety of the nursing facility's residents; or the nursing facility was designated a poor performing nursing facility.

(f) *Waiver revocation.* The Department will revoke a waiver, recover any funds paid under the waiver, or take other actions as it deems appropriate if it determines that:

(1) The applicant failed to disclose information on its waiver application that would have rendered the legal entity or nursing facility ineligible to receive a waiver under subsections (d) and (e).

(2) The legal entity or nursing facility violate any one or more of the agreements in subsection (d)(1)(ii), (v) and (vii)—(xii).

(g) *Policy regarding capital component payments to participating nursing facilities granted waivers under Chapter 1181.* Waivers of the moratorium regulations granted to nursing facilities under Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulation in § 1187.113(a).

(h) *Effectiveness of waivers granted under this section.* Waivers authorized under this section will remain valid only during the time period in which this section is in effect.

(i) *Definitions*. The following words and terms, when used in this section, have the following meanings, unless the content clearly indicate otherwise:

Applicant—A person with authority to bind the legal entity who submits a request to the Department to waive § 1187.113(a) to permit capital component payments to a nursing facility provider for postmoratorium beds.

Day-one MA eligible—An individual who meets one of the following conditions:

(i) Is or becomes eligible for MA within 60 days of the first day of the month of admission.

(ii) Will become eligible for MA upon conversion from payment under Medicare or a Medicare supplement policy, if applicable.

(iii) Is determined by the Department, or an independent assessor, based upon information available at the time of assessment, as likely to become eligible within 60 days of the first day of the month of admission or upon conversion to MA from payment under Medicare, or a Medicare supplement policy, if applicable.

Owner—A person having an ownership interest in a nursing facility enrolled in the MA Program, as defined in section 1124(a) of the Social Security Act.

Legal entity—A person authorized as the licensee by the Department of Health to operate a nursing facility that participates in the MA Program.

Person—An individual, corporation, partnership, organization, association or a local governmental unit, authority or agency thereof.

Post-moratorium beds—Nursing facility beds that were built with an approved CON or letter of nonreviewability dated after August 31, 1982, or nursing facility beds built without an approved CON or letter of nonreviewability after December 18, 1996.

Pre-moratorium beds—Nursing facility beds that were built under an approved CON or letter of nonreviewability dated on or before August 31, 1982, and for which the Department is making capital component payments.

Primary service area—The county in which the nursing facility is physically located. If the provider demonstrates to the Department's satisfaction that at least 75% of its residents originate from another geographic area, the Department will consider that geographic area to be the provider's primary service area.

§ 1187.114. Adjustments relating to sanctions and fines.

Nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1187.115. Adjustments relating to errors and corrections of nursing facility payments.

Nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.116. [Reserved].

SUBCHAPTER I.
ENFORCEMENT OF COMPLIANCE FOR NURSING FACILITIES WITH DEFICIENCIES

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SUBCHAPTER J.
NURSING FACILITY RIGHT OF APPEAL

§ 1187.141. Nursing facility's right to appeal and to a hearing.

(a) A nursing facility has a right to appeal and have a hearing if the nursing facility does not agree with the Department's decision regarding:

(1) The peer group prices established annually by the Department for the peer group in which the nursing facility is included. The nursing facility may appeal the peer group prices only as to the issue of whether the peer group prices were calculated in accordance with § 1187.96 (relating to price and rate setting computations).

(i) A nursing facility may not challenge the validity or accuracy of any adjustment (except as provided in § 1187.141(10)) or any desk or field audit findings relating to the database or total facility CMIs used by the Department in calculating the peer group prices as a basis for its appeal of the peer group prices.

(ii) If more than one nursing facility in a peer group appeals the peer group prices established by the Department, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(2) The findings issued by the Department in a desk or field audit of the nursing facility's MA-11 cost report.

(3) The Department's denial, nonrenewal or termination of the nursing facility's MA provider agreement.

(4) The MA CMI established quarterly by the Department for the facility.

(5) The Department's imposition of sanctions or fines on the nursing facility under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(6) The total facility CMI established annually by the Department for the nursing facility.

(7) The rate established annually by the Department for the nursing facility for resident care cost, other resident related cost, administrative cost and capital cost.

(8) The quarterly adjustment made by the Department to the nursing facility's rate based upon the facility's MA CMI. The facility may appeal the quarterly rate adjustment only as to the issue of whether the quarterly rate adjustment was calculated correctly.

(9) The disproportionate share incentive payment made annually by the Department to the nursing facility. A nursing facility may appeal its disproportionate share incentive payment only as to the issue of whether the Department used the correct number of MA days of care and the correct inflation factor in calculating the facility's payment.

(10) A retrospective gross adjustment made under § 1187.108 (relating to gross adjustments to nursing facility payments), for the peer group in which the nursing facility is included. The nursing facility may appeal the gross adjustment only as to the issue of whether the adjustment was calculated in accordance with a final administrative action or court order.

(i) A nursing facility may not challenge the validity or accuracy of the underlying action or order which resulted in the retrospective gross adjustment.

(ii) If more than one nursing facility in a peer group appeals a retrospective gross adjustment, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(b) A nursing facility appeal is subject to § 1101.84 (relating to provider right of appeal).

(c) A nursing facility's appeal shall be filed within the following time limits:

(1) A nursing facility's appeal of the peer group prices shall be filed within 30 days of the date on which the Department publishes the peer group price in the *Pennsylvania Bulletin*.

(2) A nursing facility's appeal of the decisions listed in subsection (a)(2)—(10) shall be filed within 30 days of the date of the Department's letter transmitting or notifying the facility of the decision.

(d) A nursing facility's appeal shall meet the following requirements:

(1) A nursing facility's appeal shall be in writing, shall identify the decision appealed and, in appeals involving decisions identified in subsection (a)(2)—(10), shall enclose a copy of the Department's letter transmitting or notifying the nursing facility of the decision.

(2) A nursing facility's appeal shall state in detail the reasons why the facility believes the decision is factually or legally erroneous and the specific issues that the facility will raise in its appeal, including issues relating to the validity of Department regulations. In addition, a nursing facility appeal of findings in a desk or field audit report shall identify the specific findings that the facility believes are erroneous and the reasons why the findings are erroneous. Reasons and issues not stated in a nursing facility's appeal shall be deemed waived and will not be considered in the appeal or any subsequent related appeal, action or proceeding involving the same decision. Desk or field audit findings not identified in a nursing facility appeal will be deemed final and will not be subject to challenge in the appeal or any subsequent related appeal, action or proceeding involving the same desk or field audit.

(3) A nursing facility may amend its appeal in order to meet the requirements of paragraph (2). A nursing facility shall file its amended appeal within 90 days of the date of the decision appealed. An amended appeal shall be permitted only if the nursing facility's appeal was filed in accordance with the time limits set forth in subsection (c). No subsequent amendment of an appeal will be permitted except under § 1187.1(d) (relating to policy).

(e) An appeal or an amended appeal shall be mailed to the Executive Director, Office of Hearings and Appeals, Department of Human Services, Post Office Box 2675, Harrisburg, Pennsylvania 17105. The date of filing is the date of receipt of the appeal or amended appeal by the Office of Hearings and Appeals.

(f) The Department may reopen an audit or a prior year's audit if an appeal is filed.

§ 1187.151. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Exceptional DME grant or *grant*—Authorization permitting exceptional payments under specified terms to a nursing facility, in addition to the nursing facility's case-mix per diem rate, for nursing facility services that are provided to a specified resident and that involve the use of certain exceptional DME. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the exceptional DME and the related services and items specified in the grant.

Resident—An MA eligible resident of a nursing facility enrolled in the MA Program who, in a request for an exceptional DME grant, is identified as needing exceptional DME.

§ 1187.152. Additional reimbursement of nursing facility services related to exceptional DME.

(a) The necessary, reasonable and prudent costs incurred by a nursing facility related to the purchase or rental, and the use of DME in providing nursing facility services to residents are allowable costs and included in the calculation of the case-mix per diem rates subject to this chapter. Any costs incurred in excess of the costs identified in a grant are not allowable costs under this chapter.

(b) When a nursing facility provides nursing facility services involving exceptional DME to an MA eligible resident, the nursing facility may, in addition to the submission of invoices for payment based upon the nursing facility's case-mix per diem rate, seek authorization for additional payment by requesting a grant from the Department in accordance with § 1187.153(a) (relating to exceptional DME grants—process).

(c) The Department will issue a grant to a nursing facility if the Department determines that all of the following conditions are met:

(1) The nursing facility's request for the grant complies with all applicable Department instructions.

(2) The specified DME is medically necessary as defined in § 1101.21 (relating to definitions).

(3) The DME specified in the nursing facility's request is exceptional DME as defined in § 1187.2 (relating to definitions).

(4) The nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME.

(5) The nursing facility certifies to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

§ 1187.153. Exceptional DME grants—process.

(a) *Requests for exceptional DME grants.*

(1) A nursing facility shall request a grant in writing on forms designated by the Department and completed in accordance with all applicable Department instructions. The request shall be accompanied by the necessary supporting documentation specified in the Department's instructions and submitted to the Department within 30 days from the date on which the nursing facility purchases or rents the DME for which the nursing facility is requesting the grant.

(2) The nursing facility shall provide copies of the nursing facility's request to the resident and the resident's authorized representative, if any, when the nursing facility submits the request to the Department.

(b) *Notification by the Department.* The Department will send written notice of the Department's decision to approve or deny a nursing facility's request for a grant to the nursing facility, the resident and the resident's authorized representative, if any.

§ 1187.154. Exceptional DME grants—general conditions and limitations.

(a) *Scope and effect of an exceptional DME grant.*

(1) A grant authorizes exceptional payments to a nursing facility in addition to the nursing facility's case-mix per diem payment rate for nursing facility services provided to the resident. The amount of the exceptional payments authorized by the grant is deemed to be the necessary, reasonable and prudent cost of the exceptional DME and the related services and items identified in the nursing facility's grant.

(2) A grant does not authorize exceptional payments for nursing facility services that are provided to MA residents other than the resident, nor does it limit costs that are, or must be, incurred by a nursing facility to provide services to any of the nursing facility's residents (including the resident) in accordance with applicable law and regulations.

(b) *Applicability of laws.* Nursing facility services provided by a nursing facility receiving a grant, including services paid by the grant, remain subject to applicable Federal and State laws and regulations, including the laws and regulations governing the MA Program.

(c) *Reporting of exceptional DME costs and grant payments.*

(1) The nursing facility shall report on the MA-11, the costs related to the acquisition of exceptional DME and related services and items paid by a grant. In identifying the nursing facility's allowable costs, the nursing facility shall adjust those reported costs to the necessary, reasonable and prudent cost amounts identified in the nursing facility's grant.

(2) The nursing facility shall offset all payments made by the Department under a grant against the allowable cost of the exceptional DME and related services and items paid by the grant.

(3) The nursing facility shall identify and report in the MA-11, the costs related to the acquisition of exceptional DME and related services and items, the adjustment to the amount identified in the grant, and the offset of the payment made by the Department under the grant using the accrual basis of accounting.

(d) *Payment in full.* A grant does not waive the preclusion on supplementation established by law. Payment made by the Department under a grant is payment in full for nursing facility services involving the exceptional DME and any related services and items. The entire payment for all MA nursing facility services provided to the resident, including the exceptional DME and any related services and items shall include both of the following:

(1) The nursing facility's case-mix per diem rate.

(2) The exceptional payments authorized by the grant.

(e) *Utilization review.* Nursing facility services paid by a grant are subject to utilization review by the Department, including assessments of the resident's continuing need for the exceptional DME.

(f) *Dispute resolution.* A dispute relating to a grant, including a dispute relating to payments which the nursing facility believes are authorized by the grant and a dispute arising from the termination, suspension or recovery actions taken under § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), shall be brought initially and exclusively for adjudication to the Department's Bureau of Hearings and Appeals.

(g) *Records.* In addition to the nursing facility's existing obligations to maintain and provide documents and records, a nursing facility receiving a grant shall maintain and, upon request, provide to the Department additional documents and records as may be necessary for the Department to determine the nursing facility's compliance with this subchapter and the terms of the nursing facility's grant, including documents and records as may be necessary for the Department to determine the maximum allowable cost of the exceptional DME as specified in § 1187.155(b) (relating to exceptional DME grants—payment conditions and limitations).

(h) *Term of the grant.* A grant is effective on the date specified in the nursing facility's grant and ends on the date the grant is terminated under § 1187.157.

(i) *Acquisition, maintenance, use and disposal of exceptional DME.*

(1) A nursing facility shall obtain exceptional DME and related services and items paid by a grant at the lowest practicable cost and shall purchase by means of competitive bidding whenever required by law.

(2) Unless otherwise approved in writing by the Department, a nursing facility may use exceptional DME paid by a grant only as specified by the nursing facility's grant.

(3) Except as specified otherwise in paragraph (5), a nursing facility has title to any exceptional DME and related items purchased by the nursing facility under the grant.

(4) If an item of exceptional DME purchased under a grant is no longer necessary to provide care and services to the resident, and subject to paragraph (2), the nursing facility shall make the item available for the use, as necessary, in the care and treatment of other MA residents of the nursing facility unless directed by the Department to transfer the exceptional DME in accordance with paragraph (5).

(5) Upon termination of a grant, the Department may direct that the nursing facility transfer the exceptional DME and related items to another provider designated by the Department or to the resident. Title to the transferred exceptional DME and related items shall then vest in the designated provider or the resident. If a transfer is required under this paragraph, § 1187.61(c)(1) (relating to movable property cost policies) does not apply.

(6) A nursing facility shall, in accordance with sound business practice, maintain and administer a program for the maintenance, repair, protection, preservation and insurance of exceptional DME paid by a grant.

(7) If a nursing facility is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to exceptional DME paid by a grant, the nursing facility shall, at the Department's direction, use the proceeds to replace, repair or renovate the property involved.

§ 1187.155. Exceptional DME grants—payment conditions and limitations.

(a) *Authorization of exceptional payments.* Exceptional payments authorized by an exceptional DME grant will be paid as follows:

(1) *Periodic payments.* Unless the grant authorizes a lump sum payment under paragraph (2), the grant will authorize exceptional payments to the nursing facility on a specified periodic basis. Authorization for periodic payments will continue during the term of the nursing facility's grant except during a period of suspension as specified in § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

(2) *Lump sum payment.* The grant may authorize a lump sum exceptional payment to the nursing facility if the Department determines that a lump sum payment is in the best interest of the MA Program. The amount of this payment will be based upon and limited by the necessary, reasonable and prudent costs incurred by the nursing facility to purchase exceptional DME and related items.

(b) *Maximum allowable payment.* The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following:

(1) The lower of the nursing facility's costs to acquire the exceptional DME and related services and items; or, in the event the nursing facility is acquiring the exceptional DME or related services and items from a related party as defined in § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the nursing facility.

(2) The applicable MA outpatient fee schedule amount, if any.

(3) Eighty percent of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

(c) *Additional conditions and limitations.* Exceptional payments made by the Department to a nursing facility under a grant are subject to the following:

(1) The conditions and limitations set forth in Chapter 1101 (relating to general provisions), including §§ 1101.64 and 1101.68 (relating to third-party medical resources; and invoicing for services).

(2) The terms of the nursing facility's grant.

§ 1187.156. Exceptional DME notification and reporting requirements.

(a) *Status reports.* A nursing facility receiving a grant shall submit periodic status reports to the Department as specified in the nursing facility's grant.

(b) *Notices.* A nursing facility receiving a grant shall notify the Department in writing within 5 days of any of the following occurrences:

(1) The resident dies.

(2) The resident ceases to be MA eligible.

(3) The resident is transferred or discharged from the nursing facility, whether or not there is intent to return.

(4) The nursing facility determines, or is advised by the resident's attending physician, that the exceptional DME is no longer medically necessary.

(5) The resident notifies the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(6) The nursing facility ceases to use the exceptional DME or make that DME available to the resident in the course of providing nursing facility services to the resident.

§ 1187.157. Termination or suspension of exceptional DME grants and recovery of exceptional payments.

(a) *Termination or suspension of an exceptional DME grant.*

(1) *Automatic termination.* Any of the following conditions shall cause termination of a nursing facility's grant without further notice or action by the Department:

(i) The resident dies.

(ii) The resident ceases to be MA eligible.

(iii) The resident is transferred or discharged from the nursing facility with no intent to return.

(iv) The resident's attending physician notifies the nursing facility that the exceptional DME is no longer medically necessary.

(v) The resident notifies the Department or the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(vi) The nursing facility is no longer enrolled in the MA Program.

(2) *Termination upon notice.* The Department may terminate a grant upon written notice to the nursing facility if any one or more of the conditions in subparagraphs (i)—(vi) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The Department determines that the exceptional DME is no longer medically necessary.

(ii) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(iii) There is a change in state or federal law or regulations governing payments to MA providers of nursing facility services.

(iv) Exceptional DME payments are no longer authorized under the Commonwealth's approved Medicaid State Plan.

(v) The nursing facility has violated the terms of the grant.

(vi) The nursing facility changes ownership.

(3) *Suspension of grant payments.* The Department may suspend payments under a grant upon written notice to the nursing facility if one or more of the conditions in subparagraphs (i) and (ii) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(ii) The resident is absent from the nursing facility because of therapeutic leave.

(4) *Termination or suspension date.* A termination under paragraph (1) is effective as of the date on which the condition giving rise to the automatic termination first arises. A termination under paragraph (2) is effective on the date specified in the Department's written notice to the nursing facility. A suspension under paragraph (3) is effective on the date and for the period specified in the Department's written notice to the nursing facility.

(5) *Effect of termination.*

(i) Termination of an exceptional DME grant, whether automatic or by written notice, terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident after the termination date.

(ii) Termination of the grant ends the nursing facility's grant and the nursing facility's duty and obligation to comply with the terms of the grant or the requirements of this subchapter, except as may be otherwise specified in the grant or in this subchapter.

(iii) Termination of a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(6) *Effect of suspension.*

(i) Suspension of payments under a grant terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident for the period specified in the notice of suspension.

(ii) Suspension of payments under a grant does not terminate the nursing facility's grant or the nursing facility's duty and obligation to comply with the terms of the grant or the requirements of this subchapter.

(iii) Suspension of payments under a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(b) *Recovery of exceptional DME grant payments.*

(1) If a grant is terminated or if payments under a grant are suspended, the Department will recover any exceptional payments made to the nursing facility for services provided after the termination date or during the period of suspension.

(2) If the nursing facility violates this subchapter or the terms of its grant, the Department may recover exceptional payments made to the nursing facility in addition to or instead of terminating the nursing facility's grant.

(c) *Rights and remedies.* The rights and remedies available to the Department under this section are in addition to any rights, remedies and sanctions otherwise available to the Department under law and regulation.

§ 1187.158. Appeals.

(a) *Appeals.* An appeal may be filed by the resident or the resident's authorized representative, by the nursing facility, or by both, from the Department's decision to deny, terminate or suspend a grant, subject to the following:

(1) If the Department denies a grant because the DME is not exceptional DME, an appeal of the denial may be filed solely on the basis that the DME is exceptional DME as defined in § 1187.2 (relating to definitions).

(2) If the Department automatically terminates a grant under § 1187.157(a)(1) (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), an appeal of the termination may be filed solely on the basis that none of the conditions specified in § 1187.157(a)(1)(i)—(vi) has occurred.

(3) If a resident appeals the denial, termination or suspension of a grant, Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings) applies.

(4) If a nursing facility appeals the denial, termination or suspension of a grant, § 1187.141(b), (d) and (e) (relating to nursing facility's right to appeal and to a hearing) apply.

(5) An appeal from the Department's decision denying a request for a grant shall be received in the Department's Bureau of Hearings and Appeals within 30 days of the date of the Department's written notice.

(6) If the resident or the nursing facility timely appeals the Department's decision to deny, suspend or terminate a grant, the Department's decision is not final until the Department issues a final adjudication on the appeal.

(b) *Effect of decisions.*

(1) *Effect on subsequent grant requests.* The denial or termination of a grant, does not prohibit a nursing facility from submitting a new request for an exceptional DME grant for the same resident, if the nursing facility determines that there has been a change in the resident's condition since the denial or termination.

(2) *Effect on services.*

(i) If the Department determines that DME specified in the nursing facility's request is medically necessary but denies the request because the DME is not exceptional DME, the nursing facility shall, as a part of the nursing facility services that it provides to the resident, provide the DME to the resident, unless the resident refuses the DME, regardless of whether the nursing facility or resident appeals the Department's decision. If the resident refuses the DME, the nursing facility shall notify the Department in accordance with § 1187.22(17) (relating to ongoing responsibilities of nursing facilities).

(ii) If the Department determines that the DME specified in the nursing facility's request is exceptional DME but denies the request because the DME is not medically necessary, the nursing facility may provide the DME and charge the resident in accordance with and subject to applicable Federal and state requirements, including 42 CFR 483.10(c)(8) (relating to resident rights) and § 1101.63(a) (relating to payment in full), if, after receiving actual notice of the Department's denial, the resident requests that the nursing facility provide the DME. If the resident or nursing facility appeals the Department's determination to deny the exceptional DME grant and the appeal is sustained, the nursing facility shall refund any payment made by the resident within 60 days from the date of the Department's final adjudication sustaining the appeal.

(iii) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3), and the resident or the resident's authorized representative appeals the termination or suspension within 10-calendar days of the date on which the Department's notice was mailed, the Department will continue to make payments under the grant pending the outcome of the hearing on the resident's appeal. If, after the hearing, the Department denies the resident's appeal, the Department will recover any payments made under the grant on or after the termination date or during the period of suspension specified in the Department's notice.

(iv) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3), and the resident or the resident's authorized representative does not appeal the termination or suspension, or appeals more than 10-calendar days from the date on which the Department's notice was mailed, the Department will cease payments under the grant on the termination date or during the period of suspension specified in the Department's notice.

Upper Payment Limit Phase-Out Amounts for State Fiscal Years 2003-2004 through 2009-2010.

UPL Phase-Out Period	Phase-Out Amount
2003-2004	$1,135,586,072
2004-2005	$935,188,530
2005-2006	$734,790,988
2006-2007	$534,393,446
2007-2008	$333,995,903
2008-2009	$133,598,361
2009-2010	$0

For FYs 2009-2010 and 2010-2011, the Department will calculate the BAF for nonpublic nursing facilities as set forth below.

Nonpublic Nursing Facilities' BAF Determination.

Base BAF Formula - Prior to establishing the July rate for each rate year, the Department will use the following formula to determine the base BAF:

Target rate divided by the acuity-adjusted weighted average rate equals the base BAF.

If the base BAF as calculated is greater than 1.0, the base BAF will equal 1.0.

April BAF Formula- Prior to establishing the April rate for each rate year, the Department will use the following formula to determine the April BAF:

The weighted average April rate will be compared to the April target rate. If the weighted average April rate is less than the April target rate and the difference is $.50 or more, the formula for the April BAF will be the April target rate divided by the weighted average April rate at 100% equals the April BAF. Otherwise, the April SAF is equal.to the base BAF.

Terms Related to the BAF Determination.

The following words and terms, when used in the BAF determination; have the following meanings, unless the context clearly indicates otherwise:

Acuity-adjusted weighted average rate - The weighted average July rate at 100% adjusted by the acuity factor.

Acuity factor - The percentage of change from the July rate to the October, January and April rates representing the estimated quarterly change in payments for the nonpublic nursing facilities. (See 55 Pa.Code § 1187.95(b) (relating to general principles for rate and price setting)).

April BAF- The BAF applied to each nonpublic nursing facility's April rate.

April target rate - The rate year's statewide day-weighted average April rate needed to meet the rate year target rate.

Base BAF - The BAF applied to each nonpublic nursing facility's July, October and January rates.

Base days - The source of days for the day-weighted calculation used in determining the base rate, the weighted average April rate at 100% and the weighted average July rate at 100%. The base days are the sum of each nonpublic nursing facility's paid facility days, therapeutic leave days and 1/3 of the

hospital bed reserve days from the PROMISe data file used to determine disproportionate share payments preceding the rate year used to determine the base rate.

Base rate - For FY 2009-2010, the statewide day-weighted average April 2009 rate for nonpublic nursing facilities, calculated using base days. For FY 2010-2011, the base rate is the FY 2009-2010 target rate.

Target rate - The base rate multiplied by one plus the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the applicable rate year.

Weighted average April rate - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days and the base SAF.

Weighted average April rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days, prior to application of a BAF.

Weighted average July rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' July rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services),calculated using base days prior to application of the base BAF.

FY 2011-2012, the Department intends to calculate the BAF for nonpublic nursing facilities as set forth below.

Nonpublic Nursing Facilities' BAF Determination

Quarterly BAF Formula - Prior to establishing the MA nonpublic nursing facility quarterly rates for the 2011-2012 rate year, the Department will use the following formula to determine the Quarterly BAF:

Annual target rate divided by the weighted average quarterly rates at 100% equals the Quarterly BAF.

If the Quarterly BAF as calculated is greater than 1.0, the Quarterly BAF will equal 1.0.

Terms Related to the BAF Determination

The following words and terms, when used in the 2011-2012 BAF determination; have the following meaning, unless the context dearly indicates otherwise:

Annual target rate - The base rate multiplied by one plus the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the 2011-2012 rate year. Based on this calculation the annual target rate for the 2011-2012 BAF determination equals $190.85.

Base days - The source of days for the day-weighted calculation used in determining the base rate and the weighted-average quarterly rates 'at 100%. The base days are the sum of each nonpublic nursing facility's paid facility days, therapeutic leave days and 1/3 of the hospital bed reserve days from the PROMISe data file used to determine disproportionate share payments preceding the rate year used to determine the base rate.

Base rate - For fiscal year 2011-2012, the projected statewide day-weighted average rate for fiscal year 2010-2011 based on the funds appropriated for fiscal year 2010-2011. The base rate for the 2011-2012 BAF determination is $190.85.

Quarterly BAF - The BAF applied to each nonpublic nursing facility's quarterly rate, as calculated for the quarter.

Weighted-average quarterly rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' quarterly rates, as applicable, determined in accordance with 55 Pa. Code Chapter 1187 (relating to nursing facility services), calculated using base days, prior to application of a BAF.

For FY2012-2013. the Department will calculate the BAF for nonpublic nursing facilities asset forth below.

Nonpublic Nursing Facilities' BAF Determination.

Base BAF Formula - Prior to establishing the July rate for the rate year, the Department will use the following formula to determine the base BAF:

Target rate divided by the acuity-adjusted weighted average rate equals the base BAF.

If the base BAF as calculated is greater than 1.0, the base BAF will equal 1.0.

April BAF Formula- Prior to establishing the April rate for the rate year, the Department will use the following formula to determine the April BAF:

The weighted average April rate will be compared to the April target rate. If the difference between the weighted average April rate and the April target rate is $.50 or more, the formula for the April BAF will be the April target rate divided by the weighted average April rate at 100% equals the April BAF. Otherwise, the April BAF is equal to the base BAF.

Terms Related to the BAF Determination.

The following words and terms, when used in the BAF determination; have the following meanings, unless the context clearly indicates otherwise:

Acuity-adjusted weighted average rate - The weighted average July rate at 100% adjusted by the acuity factor.

Acuity factor - The percentage of change from the July rate to the October, January and April rates representing the estimated quarterly change in payments for the nonpublic nursing facilities. (See 55 Pa.Code § 1187.95(b) (relating to general principles for rate and price setting)).

April BAF - The BAF applied to each nonpublic nursing facility's April rate.

April target rate - The rate year's statewide day-weighted average April rate needed to meet the rate year target rate.

Base BAF - The BAF applied to each nonpublic nursing facility's July, October and January rates. The base BAF for the 2012-2013 rate year is .84559.

Base days - The source of days for the day-weighted calculation used in determining the base rate, the weighted average April rate at 100% and the weighted average July rate at 100%. For FY 2012-2013, the base days are the sum of each nonpublic nursing facility's paid facility days, therapeutic leave days and 1/3 of the paid hospital bed reserve days from the PROMISe data file used to determine the June 30, 2011 disproportionate share payments.

Base rate -The base rate is the prior year's annual target rate. The base rate for the 2012-2013 BAF determination is $190.85.

Target rate - The base rate multiplied by one plus the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the applicable rate year.

Weighted average April rate - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days and the base BAF.

Weighted average April rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days, prior to application of a BAF.

Weighted average July rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' July rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services),calculated using base days prior to application of the base BAF.

For FY 2013-2014 through 2015-2016 and 2016-2017 the Department will calculate the BAF for nonpublic nursing facilities as set forth below.

Nonpublic Nursing Facilities' BAF Determination.

Base BAF Formula – Prior to establishing the July rate for the rate year, the Department will use the following formula to determine the base BAF:

Target rate divided by the acuity adjusted weighted average rate equals the base BAF.

If the base BAF as calculated is greater than 1.0, the base BAF will equal 1.0.

April BAF Formula- Prior to establishing the April rate for the rate year, the Department will use the following formula to determine the April BAF:

The weighted average April rate will be compared to the April target rate. If the difference between the weighted average April rate and the April target rate is $.25 or more, the formula for the April BAF will be the April target rate divided by the weighted average April rate at 100% equals the April BAF. Otherwise, the April BAF is equal to the base BAF.

Terms Related to the BAF Determination.

The following words and terms, when used in the BAF determination, have the following meanings, unless the context clearly indicates otherwise:

Acuity-adjusted weighted average rate - The weighted average July rate at 100% adjusted by the acuity factor.

Acuity factor- The percentage of change from the July rate to the October; January and April rates representing the estimated quarterly change in payments for the nonpublic nursing facilities. (See 55 Pa.Code § 1187.95(b) (relating to general principles for rate and price setting)).

April BAF - The BAF applied to each nonpublic nursing facility's April rate.

April target rate - The rate year's statewide day-weighted average April rate needed to meet the rate year target rate.

Base BAF - The BAF applied to each nonpublic nursing facility's July, October and January rates.

Base days - The source of days for the day-weighted calculation used in determining the base rate, the weighted average April rate at 100% and the weighted average July rate at 100%. The base days are the sum of each non public nursing facility's paid facility days, therapeutic leave days and 1/3 of the paid hospital bed reserve days from the PROMISe data file used to determine the June 30 disproportionate share payments preceding the rate year used to determine the base rate.

Base rate -The base rate is the prior year's annual target rate.

Target rate - The base rate multiplied by one plus the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the applicable rate year.

Weighted average April rate - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days and the base BAF.

Weighted average April rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' April rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days, prior to application of a BAF.

Weighted average July rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' July rates for the applicable rate year determined in accordance with 55 Pa.Code Chapter 1187 (relating to nursing facility services), calculated using base days prior to application of the base BAF.

For FYs 2017-2018 through 2022-2023, the Department intends to calculate the BAF for nonpublic nursing facilities as set forth below.

Nonpublic Nursing Facilities' BAF Determination

Quarterly BAF Formula - Prior to establishing the MA nonpublic nursing facility quarterly rates for the 2017-2018 through 2022-2023 rate years, the Department will use the following formula to determine the Quarterly BAF:

Annual target rate divided by the weighted average quarterly rate at 100% equals the Quarterly BAF.

If the Quarterly BAF as calculated is greater than 1.0, the Quarterly BAF will equal 1.0.

Terms Related to the BAF Determination

The following words and terms, when used in the 2017-2018 through 2022-2023 BAF determinations; have the following meaning, unless the context clearly indicates otherwise:

Annual target rate - The base rate multiplied by one plus the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the applicable rate year.

Base days - The source of days for the day-weighted calculation used in determining the base rate and the weighted-average quarterly rates at 100%. The base days are the sum of each nonpublic nursing facility's paid facility days, therapeutic leave days and 1/3 of the hospital bed reserve days for dates of service for the quarter beginning six months prior to the quarterly rate for which the BAF is being calculated.

Base rate - For FY 2019-2020, the base rate is the prior year's target rate in effect as of January 1, 2019. For FYs 2017-2018, 2018-2019, 2020-2021, 2021-2022 and 2022-2023, the base rate is the prior year's annual target rate.

Quarterly BAF - The BAF applied to each nonpublic nursing facility's quarterly rate, as calculated for the quarter.

Weighted-average quarterly rate at 100% - The statewide day-weighted average of the nonpublic nursing facilities' quarterly rates, as applicable, determined in accordance with 55 Pa. Code Chapter 1187 (relating to nursing facility services), calculated using base days, prior to application of a BAF.

Methods and Standards Governing Payment
for
County Nursing Facility Services

Effective July 1, 2006, the Department will set rates for county MA nursing facility providers in accordance with 55 Pa. Code Chapter 1189 (relating to county nursing facility services) of the State regulation.

A. Per Diem Rate Setting.

1. For the rate setting year beginning July 1, 2006, and ending June 30, 2007) the per . diem rate paid to a county nursing facility for an MA resident will be the facility's April 1, 2006 case-mix per diem rate as calculated under Subchapter G (relating to rate setting) of Chapter 1187 (relating to nursing facility services) multiplied by a budget adjustment factor of 1.04.

2. For rate setting year 2007-2008, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor for rate setting year 2007-2008 shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities over the three year period commencing July 1, 2005, and ending June 30, 2008, from the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities in rate year 2004-2005 to 10.12%. The formula for this budget adjustment factor as it applies to county nursing facilities is as follows: BAF = 1.00 + 0.03. For the rate setting year beginning July 1, 2007, and ending June 30, 2008, the per diem rate paid to a county nursing facility for an MA resident will be the facility's July 1, 2006 per diem rate calculated m accordance with paragraph 1 above, multiplied by the budget adjustment factor.

3. For rate setting year 2008-2009, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the aggregate percentage rate of increase for the period that begins July 1,2005 and ends on June 30, 2009 is limited to the amount permitted by the funds appropriated by the General Appropriations Act of 2008. The formula for this budget adjustment factor as it applies to county nursing facilities is as follows: BAF = 1.00 + 0.01. For the rate setting year beginning July 1, 2008, and ending June 30, 2009, the per diem rate paid to a county nursing facility for an MA resident will be the facility's July 1, 2007 per diem rate calculated in accordance with paragraph 1 above, multiplied by the budget adjustment factor of 1.01.

4. For rate setting year 2009-2010 and 2010-2011, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the aggregate percentage rate of increase for the period that begins July 1, 2005 and ends on June 30, 2011 is limited to the amount permitted by the funds appropriated by the General Appropriations Acts. The formula for this budget adjustment factor as it applies to county nursing facilities for the 2009-2010 rate year is as follows: BAF = 1.00 + 0.01. For the rate year beginning July 1, 2009, and ending June 30, 2010, the per diem rate paid to a county nursing facility for an MA resident will be the facility's July 1, 2008 per diem rate calculated in accordance with paragraph 1 above, multiplied by the budget adjustment factor of 1.01.

5. For rate setting year 2011-2012 and 2012-2013, the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget adjustment factor shall limit the estimated Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the average payment rate is limited to the amount permitted by the funds appropriated by the General Appropriations Acts. For the rate year 2011-2012 and 2012-2013, the per diem rate paid to a county nursing facility for an MA resident will be the facility's prior year per diem rate as calculated under Chapter 1189, Subchapter D and § 1189.91(b) multiplied by the applicable budget adjustment factor. The budget adjustment factor for 2011-2012 as it applies to county nursing facilities is 1.0 and the budget adjustment factor for 2012-2013 as it applies to county nursing facilities is 1.0.

6. For rate setting years 2013-2014 through 2015-2016, 2016-2017 through 2018-2019, 2019-2020 through 2021-2022 and 2022-2023 through 2025-2026 the Department will apply a budget adjustment factor to county and non-public nursing facility payment rates for medical assistance nursing facility services. The budget factor shall limit the estimated Statewide day-weighted average payment rate for medical assistance nursing facility services for county and non-public nursing facilities so that the average payment rate is limited to the amount permitted by the funds appropriated by the General Appropriations Acts. The formula

for the budget adjustment factor as it applies to county nursing facilities is as follows: BAF = 1.00 + the percentage rate of change permitted by the funds appropriated by the General Appropriations Act for the applicable rate year. For the rate years 2013-2014 through 2015-2016, 2016-2017 through 2018-2019, 2019-2020 through 2021-2022 and 2022-2023 through 2025-2026 the per diem rate paid to a county nursing facility for an MA resident will be the facility's prior year per diem rate as calculated under Chapter 1189, Subchapter D and § 1189.91(b) multiplied by the applicable budget adjustment factor.

7. New county nursing facility. The per diem rate paid to a new county nursing facility for an MA resident will be the statewide average of all other county nursing facilities' per diem rates for the same rate setting year as established above.

B. Incentive Payments

1. *County MA Day One Incentive payment for FYs 2006-2007 thru 2011- 2012 and 2012-2013 thru 2015-2016.* The Department will make MA Day One Incentive (MOOI) payments to each qualified county nursing facility as an. incentive to preserve the critical safety network county nursing facilities provide to the poor and indigent residents of Pennsylvania.

a. An annual MDOI will be calculated for each qualified county nursing facility, to be paid out in quarterly installments.

b. To qualify for an MDOI quarterly installment payment, the facility must be a county nursing facility both during the entire quarter for which the installment payment is being made and at the time the installment payment is made.

c. The Department will calculate each qualified county nursing facility's MOOI quarterly installment payment based on the following formula:

(i) The total funds allocated for the MOOI payments for the rate year will be divided by the total MA days for all county nursing facilities to determine the MDOI per diem for the rate year. The total MA days used for each county nursing facility will be the MA days identified on the most recent Provider Reimbursement and Operations Management Information System (PROMISe™) data file used to determine the facility's eligibility for disproportionate share incentive payments. The state funds allocated for FYs 2006-2007 thru 2015~2016 are as follows:

FY - 2006-2007 - $ 11,858,682
FY - 2007-2008 - $ 12,330,822
FY - 2008-2009 - $ 9,804,649
FY - 2009-2010 - $ 13,868,883
FY - 2010-2011 - $ 13,979,899
FY - 2011-2012 - $ 20,574,781
FY - 2012-2013 - $ 23,580,105
FY - 2013-2014 - $ 24,666,449
FY - 2014-2015 - $ 20,037,185
FY - 2015-2016 - $ 74,729,967

(ii) The MDOI per diem for the rate year will be multiplied by each qualified county nursing facility's paid MA days identified on the most recent PROMISe data file used to determine eligibility for disproportionate share incentive payments, to determine its annual MDOI amount.

(iii) Each qualified county nursing facility's annual MDOI amount will be divided by four to determine the facility's MDOI . quarterly installment payments for the rate year.

d. The MDOI installment payments for each quarter of the rate year will be paid in the first month of the following quarter.

B. Incentive Payments.

1. County MA Day One Incentive payment for 2016~2017. The Department will make quarterly MA Day One Incentive (MOOI) payments to each qualified county nursing facility as an incentive to preserve the critical safety network county nursing facilities provide to the poor and indigent residents of Pennsylvania.

a. To qualify for a quarterly MODI payment, the facility must be a county nursing facility both during the entire quarter for which the payment is being made and at the time the payment is made. A facility will not qualify for a quarterly payment if they are located in a geographic zone where Community Health Choices operates during the entire quarter for which the payment is being made.

b. The Department will calculate each qualified county nursing facility's quarterly MODI payment based on the following formula:

(i) The total funds allocated for the quarter will be divided by the total MA days for all qualified county nursing facilities to determine the quarterly MOOI per diem. The total MA days used for each county nursing facility will be the MA days identified on the most recent Provider Reimbursement and Operations Management Information System (PROMISe™) data file used to determine the facility's eligibility for disproportionate share incentive payments. The state funds allocated for FY2016-2017 are as follows:

FY -2016-2017	Quarter 1 $2,893,014
FY -2016-2017	Quarter 2 $2,893,014
FY -2016-2017	Quarter 3 $2,893,014
FY -2016-2017	Quarter 4 $2,893,014

(ll) The quarterly MDOI per diem will be multiplied by each qualified county nursing facility's paid MA days identified on the most recent PROMISe data file used to determine eligibility for disproportionate share incentive payments, to determine its quarterly MDOI amount.

c. The MDOI payments for each quarter of the rate year will be paid in the first month of the following quarter.

B. Incentive Payments.

1. County MA Day One Incentive payment for FYs 2017-2018,2018-2019 and 2019-2020. The Department will make quarterly MA Day One Incentive (MDOI) payments to each qualified county nursing facility as an incentive to preserve the critical safety network county nursing facilities provide to Medical Assistance eligible residents of Pennsylvania.

a. To qualify for a quarterly MOOI payment, the facility must be a county nursing facility both during the entire quarter for which the payment is being made and at the time the payment is made. A facility will not qualify for a quarterly payment if they are located in a geographic zone where Community Health Choices operates during the entire quarter for which the payment is being made.

b. The Department will calculate each qualified county nursing facility's quarterly MOOI payment based on the following formula:

(i) The total funds allocated for the quarter will be divided by the total MA days for all qualified county nursing facilities to determine the quarterly MOOI per diem. The total MA days used for each county nursing facility will be the MA days identified on the most recent Provider Reimbursement and Operations Management Information System (PROMISe™) data file used to determine the facility's eligibility for disproportionate share incentive payments. The state funds allocated for FYs 2017-2018, 2018-2019 and 2019-2020 are as follows:

Fiscal Year	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
FY 2017-2018	$2,849,659	$2,849,659	$2,153,882	$2,153,882
FY 2018-2019	$1,958,577	$1,958,577	$1,255,298	$1,255,298
FY 2019-2020	$1,073,065	$1,073,065	$0	$0

(iii) The quarterly MDOI per diem will be multiplied by each qualified county nursing facility's paid MA days identified on the most recent PROMISe data file used to determine eligibility for disproportionate share incentive payments, to determine its quarterly MDOI amount

c. The MDOI payments for each quarter of the rate year will be paid in the first month of the following quarter.

2. Disproportionate Share Incentive Payment

a. A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to county nursing facilities that are not located in a geographic zone where Community HealthChoices operates at the time the payment should be made as described in subsection (d). To qualify for the payment a facility must meet the following criteria for a 12-month facility cost reporting period.

(i) The county nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(ii) The county nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

b. The disproportionate share incentive payments will be based on the following:

	Overall Occupancy	MA Occupancy (y)	Per Diem Incentive
Group A	90%	$\geq$90% y	$3.32
Group B	90%	88% $\leq$ y <90%	$2.25
Group C	90%	86% $\leq$ y <88%	$1.34
Group D	90%	84% $\leq$ y <86%	$0.81
Group E	90%	82% $\leq$ y <84%	$0.41
Group F	90%	80% $\leq$ y <82%	$0.29

c. The disproportionate share incentive payments as described in (b) above will be inflated forward using the first quarter issue CMS Nursing Home without Capital Market Basket Index, total index level, to the end point of the rate setting year for which the payments are made.

d. These payments will be made annually within 120 days after the submission of an acceptable MA cost report provided that in no case will payment be made before 210 days of the close of the county nursing facility fiscal year.

e. For the period July 1, 2005 to June 30, 2009, the disproportionate share incentive payment to qualified county nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with subparagraph c.

(i) For the period commencing July 1, 2005 through June 30, 2006, the increased incentive shall apply to MA cost reports filed for the fiscal period ending December 31, 2005.

(ii) For the period commencing July 1,2006 through June 30, 2007, the increased incentive shall apply to MA cost reports filed for the fiscal period ending December 31, 2006.

(iii) For the period commencing July 1, 2007 through June 30, 2008, the increased incentive shall apply to MA cost reports filed for the fiscal period ending December 31, 2007.

(iv) For the period commencing July 1, 2008 through June 30, 2009, the increased incentive shall apply to MA cost reports filed for the fiscal period ending December 31, 2008.

3. Pay for Performance Incentive Payment

For Fiscal Years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013 and 2013-2014 pay for performance incentive payments will be made to qualifying county nursing facilities each quarter based on the following:

(i) Qualifying criteria. A county nursing facility will qualify for the pay for performance incentive jf both of the following criteria are met:

(A) The facility is a county nursing facility at the time of payment.

(B) The facility's MA case mix index (CMI) for the picture date is higher than its facility MA CMI for the previous picture date.

Pay for Performance Payment Period	Picture	Previous Picture Date
July 1 – September 30	August 1	May 1
October 1 – December 31	November 1	August 1
January 1 – March 31	February 1	November 1
April 1 – June 30	May 1	February 1

(ii) Payment formula. The total quarterly funds available for the pay for performance incentive payment is divided by the total MA days for all county nursing facilities meeting the qualifying criteria. The MA days used for each county nursing facility will be the paid MA days identified on the most recent PROMISe data file used to determine eligibility for disproportionate share payments.

(iii) The total quarterly funds available for each quarter of FYs 2006-2007,2007-20081 2008-2009, 2009-2010, 2010-2011, 2011 ~2012, 2012-2013 and 2013-2014 are $1,625,000 per quarter.

(iv) For pay for performance payment periods beginning on or after July 1, 2010, in determining whether a county nursing facility qualifies for a quarterly pay for performance incentive payment, the facility's MA CMI for a picture date will equal the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date. An MA resident's CMI will be calculated using the RUG-III version 5.12 44 group values as set forth in Appendix A to Chapter 1187 (relating to nursing facility services) and the most recent classifiable assessment of any type.

4. Supplemental Ventilator Care Payments for County Nursing Facilities

(a) The Department will pay a supplemental ventilator care payment each calendar quarter, beginning July 1, 2012 through June 30, 2014, to county nursing facilities subject to the following:

(i) To qualify for the supplemental payment, the county nursing facility must first satisfy both of the following threshold criteria on the given Picture Date:

a. the facility must have, at least, ten MA-recipient residents who receive necessary ventilator care; and

b. the facility must have, at least, ten percent (10%) of their MA-recipient resident population receiving necessary ventilator care.

For example, a county nursing facility with 120 MA-recipient residents must have at least 12 MA-recipient residents who require necessary ventilator care. Whereas, a facility with only 60 MA-recipient residents must have at least 10 MA-recipients who receive necessary ventilator care.

(ii) For purposes of subsection (a)(I), the percentage of the county nursing facility's MA-recipient residents who receive necessary ventilator care will be calculated by dividing the total number of MA-recipient residents who receive necessary ventilator care by the total number of MA-recipient residents, and the result will be rounded to two percentage decimal points.

(iii) To qualify as a MA-recipient resident who receives necessary ventilator care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use on the Federally-approved, PA-specific MDS assessment listed on the county nursing facility's CMI Report for the given Picture Date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the county nursing facility's CMI Report for the given Picture Date.

(v) The applicable Picture Dates and the schedule for authorization of any associated quarterly supplemental ventilator care payment are as follows:

Picture Date	Supplemental Ventilator Care Payment
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a county nursing facility fails to submit a valid CMI Report for the picture date in the time frame outlined in §1187.33(a)(5) (relating to resident data and picture date reporting requirements), the facility cannot qualify for a supplemental ventilator care payment.

(b) A county nursing facility's supplemental ventilator care payment is calculated as follows:

(i) The supplemental ventilator care per diem shall equal «number of MA-recipient residents who receive necessary ventilator care/total MA-recipient residents) x $69) x (the number of MA-recipient residents who receive necessary ventilator care/total MA recipient residents).

(ii) The amount of total supplemental ventilator care payment shall equal the supplemental ventilator care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(iii) If the Department grants a waiver to the 180-day billing requirement, the MA-paid days that may be billed pursuant to the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care payment, and the Department will not retroactively revise the payment amount.

(iv) The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care payment as described above will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in Subsection (a).

(c) These payments will be made quarterly in each month listed in subsection (a).

4a. Supplemental Ventilator Care and Tracheostomy Care Payment for County Nursing Facilities

(a) The Department will pay a supplemental ventilator care and tracheostomy care payment each calendar quarter, beginning July 1, 2014, to county nursing facilities and effective January 1, 2018, to county nursing facilities that are not located in a geographic zone where Community HealthChoices operates subject to the following:

(i) To qualify for the supplemental payment, the county nursing facility must first satisfy both of the following threshold criteria on the given Picture Date:

a. the facility must have, at least, ten MA-recipient residents who receive necessary ventilator care or tracheostomy care; and

b. the facility must have, at least, ten percent (10%) of their MA-recipient resident population receiving necessary ventilator care or tracheostomy care.

For example, a county nursing facility with 120 MA-recipient residents must have at least 12 MA-recipient residents who require necessary ventilator care or tracheostomy care. Whereas, a facility with only 60 MA-recipient residents must have at least 10 MA-recipients who receive necessary ventilator care or tracheostomy care.

(ii) For purposes of subsection (a)(I), the percentage of the county nursing facility's MA-recipient residents who receive necessary ventilator care or tracheostomy care will be calculated by dividing the total number of MA-recipient residents who receive necessary ventilator care or tracheostomy care by the total number of MA-recipient residents as described in subparagraph (iv), and the result will be rounded to two percentage decimal points. (For example, .0945 will be rounded to .09 (or 9%); .1262 will be rounded to .13 (or 13%).

(iii) To qualify as a MA-recipient resident who receives necessary ventilator care or tracheostomy care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use or tracheostomy care on the Federally-approved, PA-specific MDS assessment listed on the county nursing facility's CMI Report for the given Picture Date.

(iv) The number of total MA-recipient residents is the number of MA-recipient residents listed on the county nursing facility's CMI Report for the given Picture Date. MA-pending individuals or those individuals found to be MA eligible after the county nursing facility submits a valid CMI report for the picture date as provided under § 1187.33(a)(5) (relating to resident data and picture date reporting requirements) shall not be included in the count and shall not result in an adjustment of the percent of ventilator dependent or tracheostomy care MA residents.

(v) The applicable Picture Dates and the schedule for authorization of any associated quarterly supplemental ventilator care and tracheostomy care payment are as follows:

Picture Date	Supplemental Ventilator Care and Tracheostomy Care Payment
February 1	September
May 1	December
August 1	March
November 1	June

(vi) If a county nursing facility fails to submit a valid CMI Report for the picture date in the time frame outlined in § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care and tracheostomy care payment.

(b) A county nursing facility's supplemental ventilator care and tracheostomy care payment is calculated as follows:

(i)The supplemental ventilator care and tracheostomy care per diem shall equal ((number of MA-recipient residents who receive necessary ventilator care or tracheostomy care/total MA-recipient residents) x $69) x (the number of MA-recipient residents who receive necessary ventilator care or tracheostomy care/total MA-recipient residents).

(ii) The amount of total supplemental ventilator care and tracheostomy care payment shall equal the supplemental ventilator care and tracheostomy care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(iii) If the Department grants a waiver to the 180-day billing requirement, the MA-paid days that may be billed pursuant to the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care and tracheostomy care payment, and the Department will not retroactively revise the payment amount.

(iv)The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care and tracheostomy care payment as described above will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in subsection (a).

(c) These payments will be made quarterly in each month listed in subsection (a).

5. Supplementation Payment for County Nursing Facilities

The Department will make a county nursing facility supplementation payment in fiscal years (FYs) 2013-2014, 2014-2015, 2015-2016 and 2016·2017to qualified county nursing facilities. To qualify for the supplementation payment, a county nursing facility must have an MA occupancy rate of at least 85 percent and must be located in a home rule county that was formerly a county of the second class A. The MA occupancy rate for each fiscal year will be determined by using the latest" acceptable annual cost report as of September 30 in accordance with §1189.71(b) (relating to cost reporting). A county nursing facility's supplementation payment is calculated by dividing the total funds available by the number of qualified nursing facilities.

5b. *Supplementation Payment for County Nursing Facilities*

The Department will make a county nursing facility supplementation payment in Fiscal Years 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023 and 2023-2024 to qualified county nursing facilities. To qualify, a county nursing facility must be located in a home rule county that was formerly a county of the second class A, have more than 725 beds and a Medicaid acuity of 0.79 as of August 1, 2015. The number of beds will be the number of licensed beds as of August 1, 2015, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2015, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements). A county nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior fiscal year. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior fiscal year.

The state funds allocated for FY 2018-2019 is $2,000,000.
The state funds allocated for FY 2019-2020 is $2,000,000.
The state funds allocated for FY 2020-2021 is $2,000,000.
The state funds allocated for FY 2021-2022 is $2,000,000.
The state funds allocated for FY 2022-2023 is $2,000,000.
The state funds allocated for FY 2023-2024 is $2,000,000.

5c. *Supplementation Payment for County Nursing Facilities*

(a) The Department of Human Services (Department) will make a county nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nursing facilities. To qualify, a county nursing facility must be located in a home rule county that is a county of the second class A, have more than 725 beds and a Medicaid acuity of 0.79 as of August 1, 2015. The number of beds will be the number of licensed beds as of August 1, 2015, and the Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the August 1, 2015, Picture Date in accordance with 55 Pa. Code §1187.33 (relating to resident data and picture date reporting requirements).

(b) A county nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY.

The state funds allocated for county nursing facilities for a FY are as follows:

FY 2024-2025 is $2,000,000.

6. Supplemental Ventilator Care and Tracheostomy Care Add-on Payment

The Department will make payments in fiscal years (FYs) 2016-2017, 2017- 2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance residents who required medically necessary ventilator care or tracheostomy care greater than 90 percent using the quarterly payment files located on the Department's website.

6a. The Department will make payments in FY 2023-2024 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015 and remain open as of December 13, 2023. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance residents who required medically necessary ventilator care or tracheostomy care greater than 90 percent using the quarterly payment files located on the Department's website.

The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY is as follows:

FY 2017-2018 is $750,000.
FY 2018-2019 is $1,500,000.
FY 2019-2020 is $750,000.
FY 2020-2021 is $750,000.
FY 2021-2022 is $750,000.
FY 2022-2023 is $500,000.
FY 2023-2024 is $500,000.

6b. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment*

(a) The Department of Human Services (Department) will make payments in Fiscal Year (FY) 2024-2025 to nonpublic and county nursing facilities that qualified for supplemental ventilator care and tracheostomy care payments in FY 2014-2015 and remain open as of July 11, 2024. To qualify, a nonpublic and county nursing facility had to qualify for at least one supplemental ventilator care and tracheostomy care payment in FY 2014-2015 with a percentage of Medical Assistance (MA) residents who required medically necessary ventilator care or tracheostomy care greater than 90% using the quarterly payment files located on the Department's website.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $500,000.

7. Safety Net Payments for County Nursing Facilities

The Department will make a safety net payment in Fiscal Year 2016-2017 to qualifying county nursing facilities to assure their continued operation as a safety net provider for the MA nursing facility population.

Qualification:

To qualify for a safety net payment the facility must:

(1) Be a county nursing facility both during the period for which the payment is being made and at the time the payment is made; and

(2) If located in a county with a population of less than 70,000 based on U.S. Census Bureau; 2010 Census Summary File 1; Table GCT-PH1; generated using American FactFinder; http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml: (October 2016), have an overall occupancy rate greater than 90% based on the four consecutive quarters reported by the nursing facility as of April 22, 2016 for the Nursing Facility Assessment Program beginning April 1, 2015 and ending March 31, 2016.

Calculation of Safety Net Payment:

The Department will calculate each qualifying county nursing facility's safety net payment by calculating a per diem portion of the payment and a Medicare differential portion of the payment. A qualifying county nursing facility's total safety net payment is the sum of the two proportional amounts calculated for the facility.

a. Per Diem Portion

The per diem portion of the safety net payment will be calculated using each qualifying facility's paid MA facility days and therapeutic leave days based on each qualifying facility's paid MA facility days and therapeutic leave days identified on the Provider Reimbursement and Operations Management Information System (PROMISe) data file used to determine the facility's eligibility for disproportionate share incentive payments for the period ending December 31, 2015.

Each facility's per diem portion of the safety net payment will be determined by:

(1) Dividing the funds allocated to safety net payments by the total paid MA facility days and therapeutic leave days for all county nursing facilities and multiplying that amount by 80% to determine a safety net per diem for the rate year; and

(2) Multiplying the safety net per diem by the qualifying county nursing facility's paid MA facility days and therapeutic leave days to determine the facility's per diem portion of the safety net payment rounded to the nearest cent.

b. Medicare Differential Portion

The Medicare differential portion of the safety net payment will be determined by:

(1) Calculating for each qualifying nursing facility the estimated difference between what Medicare would pay for the nursing facility services and what Medicaid would pay for FY2016-2017 excluding any anticipated safety net payments as evidence in the preliminary annual Medicare upper payment limit demonstration calculated as of February 23, 2016; and

(2) Multiplying that difference by 20% to establish each facility's Medicare differential portion of the safety net payment rounded to the nearest cent.

8. Safety Net Payments for County Nursing Facilities

The Department will make a safety net payment in Fiscal Year 2017·2018 to qualifying county nursing facilities to assure their continued operation as a safety net provider for the MA nursing facility population. Qualification: To qualify for a safety net payment the facility must be a county nursing facility both during the period for which the payment is being made and at the time the payment is made.

Qualification:

To qualify for a safety net payment the facility must be a county nursing facility both during the period for which the payment is being made and at the time the payment is made.

Calculation of Safety Net Payment:

The Department will calculate each qualifying county nursing facility's safety net payment by calculating a per diem portion of the payment and a Medicare differential portion of the payment. A qualifying county nursing facility's total safety net payment is the sum of the two amounts calculated for the facility as adjusted in paragraph c. below rounded to the nearest dollar.

a. Per Diem Portion

The per diem portion of the safety net payment will be calculated using each qualifying facility's paid MA facility days and therapeutic leave days based on each qualifying facility's paid MA facility days and therapeutic leave days identified on the Provider Reimbursement and Operations Management Information System (PROMISe TM) data file used to determine the facility's eligibility for disproportionate share incentive payments for the period ending December 31, 2016.

Each facility's per diem portion of the safety net payment will be determined by:

(1) Dividing the funds allocated to safety net payments by the total paid MA facility days and therapeutic leave days for all eligible county nursing facilities and multiplying that amount by 80% to determine a safety net per diem for the rate year; and

(2) Multiplying the safety net per diem by the qualifying county nursing facility's paid MA facility days and therapeutic leave days to determine the facility's per diem portion of the safety net payment rounded to the nearest dollar.

b. Medicare Differential Portion

The Medicare differential portion of the safety net payment will be determined by:

(1) Calculating for each county nursing facility the estimated difference between what Medicare would pay for the nursing facility services and what Medicaid would pay for FY 2017-2018 excluding any anticipated safety net payments and prior to any adjustments for the transition to the Community HealthChoices (CHC) program as demonstrated In the preliminary annual Medicare upper payment limit demonstration calculated as of October 4, 2017;

(2) Summing the differences calculated In (1);

(3) Multiplying the total from (2) by 20%; and (4) Multiplying the product calculated in

(3) by a ratio determined by dividing the difference for each qualifying county nursing facility as determined in (1) by the sum of the differences for all qualifying county nursing facilities to establish each facility's Medicare differential portion of the safety net payment rounded to the nearest dollar.

c. Adjustment for Community HealthChoices

For a county nursing facility located in a county in which the CHC Program has been implemented, the sum of the two amounts calculated for a facility under subsections (a) and (b) will be multiplied by 0.5 to determine a facility's annual safety net payment for FY 2017·2018. This adjustment is necessary to account for the estimated reduction in MA days of care paid through the MA Fee-for-Service Program due to Implementation of the CHC managed care program in a county for half of the fiscal year.

9. Safety Net Payments for County Nursing Facilities

The Department will make a safety net payment in Fiscal Years 2018-2019 and 2019-2020 to qualifying county nursing facilities to assure their continued operation as a safety net provider for the MA nursing facility population.

Qualification:

To qualify for a safety net payment, the facility must be a county nursing facility both during the period for which the payment is being made and at the time the payment is made. County nursing facilities located in a geographic zone where the CHC program will be in operation for the entire 2018-2019 or 2019-2020 fiscal years are not eligible for this payment in the applicable fiscal year.

Calculation of Safety Net Payment:

The Department will calculate each qualifying county nursing facility's safety net payment by calculating a per diem portion of the payment and a Medicare differential portion of the payment. A qualifying county nursing facility's total safety net payment is the sum of the two amounts calculated for the facility as adjusted in paragraph c. below rounded to the nearest dollar.

a. Per Diem Portion

The per diem portion of the safety net will be calculated using each qualifying facility's paid MA facility days and therapeutic leave days based on each qualifying facility's paid MA facility days and therapeutic leave days identified in the preliminary annual Medicare upper payment limit demonstration calculated as of October 2, 2018 for 2018-2019 and September 11, 2019 for 2019-2020.

Each facility's per diem portion of the safety net payment will be determined by:

(1) Dividing the funds allocated to safety net payments by the total paid MA facility days and therapeutic leave days for all qualifying county nursing facilities and multiplying that amount by 80% to determine a safety net per diem for the rate year; and

(2) Multiplying the safety net per diem by the qualifying county nursing facility's paid MA facility days and therapeutic leave days to determine the facility's per diem portion of the safety net payment rounded to the nearest dollar.

b. Medicare Differential Portion

The Medicare differential portion of the safety net payment will be determined by:

(1) Calculating, for each qualifying county nursing facility the estimated difference between what Medicare would pay for the nursing facility services and what Medicaid would pay for the applicable FYs 2018-2019 or 2019-2020 excluding any anticipated safety net payments and prior to any adjustments for the transition to the Community HealthChoices (CHC) program as demonstrated in the preliminary annual Medicare upper payment limit demonstration calculated as of October 2,2018 for 2018-2019 and September 11,2019 for 2020;

(2) Summing the differences calculated in b. (1);

(3) Multiplying the total from b. (2) by 20%; and

(4) Multiplying the product calculated in b. (3) by a ratio determined by dividing the difference for each qualifying county nursing facility as determined in b. (1) by the sum of the differences for all qualifying county nursing facilities to establish each facility's Medicare differential portion of the safety net payment rounded to the nearest dollar.

c. Adjustment for Community HealthChoices

For a county nursing facility located in a county in which the CHC Program will be in operation for part of the applicable FYs 2018-2019 or 2019-2020, the sum of the two amounts calculated for a facility under subsections (a) and (b) will be multiplied by 0.5 to determine a facility's annual safety net payment for the applicable FYs 2018-2019 and 2019-2020. This adjustment is necessary to account for the estimated reduction in MA days of care paid through the MA Fee-for-Service Program due to implementation of the CHC managed care program in a county for half of the fiscal year.

10. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment for Nonpublic and County Nursing Facilities in a Township of the First Class in a County of the Second Class A*

(a) The Department of Human Services (Department) will make a ventilator care and tracheostomy care add-on payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic and county nursing facilities located in a township of the first class in a county of the second class A. To qualify, a nonpublic and county nursing facility must be located in a township of the first class in a county of the second class A and remain open as of July 11, 2024, with a percentage of Medical Assistance (MA) recipient residents who required medically necessary ventilator care or tracheostomy care equal to or greater than 90% as of August 1, 2022.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $250,000.

11. *Supplemental Ventilator Care and Tracheostomy Care Add-on Payment for Nonpublic and County Nursing Facilities in a City of the First Class*

(a) The Department of Human Services (Department) will make a ventilator care and tracheostomy care add-on payment in Fiscal Year (FY) 2024-2025 to qualified nonpublic and county nursing facilities located in a city of the first class. To qualify, a nonpublic and county nursing facility must be located in a city of the first class, have commenced operations after December 31, 2017, and remain open as of July 11, 2024, with a percentage of Medical Assistance (MA) recipient residents who required medically necessary ventilator care or tracheostomy care equal to or greater than 90% as of August 1, 2022.

(b) The Department will calculate each qualified nursing facility's add-on payment by dividing the total funds for the supplemental ventilator care and tracheostomy care payment by the number of qualified nursing facilities.

The state funds allocated for nonpublic and county nursing facilities for a FY are as follows:

FY 2024-2025 is $250,000.

12. *Supplementation Payment for Nonprofit Nursing Facilities in a City of the Second Class A in a County of the Third Class*

(a) The Department of Human Services (Department) will make a nonprofit nursing facility supplementation payment in Fiscal Year (FY) 2024-2025 to qualified nonprofit nursing facilities located in a city of the second class A in a county of the third class. To qualify for the supplementation payment, a nonprofit nursing facility must be located in a city of the second class A in a county of the third class and have a Medicaid acuity of 1.11 as of February 1, 2023. The Medicaid acuity will be determined using the Case Mix Index (CMI) Report for the February 1, 2023, Picture Date in accordance with 55 Pa. Code § 1187.33 (relating to resident data and picture date reporting requirements).

(b) A nonprofit nursing facility's supplementation payment is calculated by multiplying the supplementation per diem by the number of paid Medical Assistance (MA) facility and therapeutic leave days for the prior FY. The supplementation per diem will be calculated by dividing the total funds available by the total number of paid MA facility and therapeutic leave days for the prior FY for qualifying facilities.

The state funds allocated for nonprofit nursing facilities for a FY are as follows:

FY 2024-2025 is $1,500,000.

C. Supplementation Payments

For State fiscal years 2005 through 2009 (the transition period), subject to the availability of sufficient county, State and Federal funds, the Department will make county supplementation payments to county nursing facilities in which MA days, as defined in 55 Pa.Code § 1187.2, account for at least 80% of the nursing facility's total resident days and the number of certified MA beds in the nursing facility is greater than 270 beds.

The Department will negotiate a total supplementation payment amount with eligible county nursing facilities. The county supplementation payments during the transition period will be based upon an executed intergovernmental transfer agreement and a subsequent transfer of funds. The total supplementation payment amount in each State fiscal year of the transition period will equal the annual amount set forth in Supplement II of Attachment 4.19D, Part I.

D. Exceptional Payments

In addition to payments based upon the county nursing facility's MA per diem rate, the Department will issue exceptional Durable Medical Equipment (DME) grants that authorize payments for certain exceptional nursing facility services involving the purchase or rental of exceptional DME, For purposes of these grants, exceptional DME must have a minimum acquisition cost that is equal to or greater than an amount specified by the Department and is either specially adapted DME or such other DME that is designated as exceptional DME by the Department. The Department will identify the minimum exceptional DME acquisition cost and other designated exceptional DME annually by notice in the Pennsylvania Bulletin.

To receive an exceptional DME grant for a resident, a county nursing facility must submit a request on forms designated by the Department. The Department will issue an exceptional DME grant if the Department determines that: (1) the county nursing facility's request complies with all applicable Department instructions; (2) the DME specified in the county nursing facility's request is medically necessary; (3) the DME specified in the county nursing facility's request is exceptional DME; (4) the county nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME: (5) the county nursing facility has exhausted all third party medical resources, and; (6) the county nursing facility has certified to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

When the Department issues an exceptional DME grant to a county nursing facility, the Department identifies the resident to whom the exceptional services are being provided, the specific equipment and related services paid by the exceptional DME grant. the amount of the exceptional payment(s) and the terms and conditions under which the payment (s) will be made. An exceptional DME grant is effective on the date specified in the county nursing facility's grant and ends on the date the exceptional DME grant is terminated pursuant to § 1187.156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following: (1) The lower of the county nursing facility's costs to obtain the exceptional DME and related services and items; or, in the event the county nursing facility is obtaining the exceptional DME or related services and items from a related party as defined in 55 Pa. Code § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the county nursing facility; (2) The applicable MA outpatient fee schedule amount, if any; or, (3) Eighty percent (80%) of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

The amount of the exceptional payment(s) authorized by the exceptional DME grant are deemed to be the necessary, reasonable and prudent costs of the exceptional DME and the related services and items identified in the county nursing facility's exceptional DME grant.

The exceptional payment is paid in either lump sum or monthly payments depending on which method is in the best interest of the MA program. Authorization for monthly payments continues during the term of the nursing facility's grant except during a period of suspension as specified in § 1187.156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

All nursing facility services provided by a county nursing facility receiving an exceptional DME grant, including services paid by the grant~ remain subject to applicable federal and state laws and regulations, including the laws and regulations governing the MA Program.

Nursing facility services paid by an exceptional DME grant are subject to review by the Department to ensure compliance with the terms and conditions of the exceptional DME grant. The Department will perform periodic assessments of each resident receiving nursing facility services paid by an exceptional DME grant to determine the continuing need for the exceptional DME.

The Department will conduct audits to ensure that a county nursing facility receiving payment authorized by an exceptional DME grant adjusts its reported costs on the cost report to account for the exceptional payments.

E. [RESERVED]

F. Allowable Program Costs and Policies

Allowable costs are those costs incurred by a county nursing facility in the course of providing nursing facility services to MA residents and one of the following applies: (1) The cost is allowable under CMS Pub. 15-1; (2) The cost is not allowable under the CMS Pub, 15-1, but is allowable as a net operating cost under Chapter 1187 (relating to nursing facility services); or (3) The cost is identified as an allowable county nursing facility cost in Part 1A of Attachment 4.19D.

The Department of Health's annual health-care associated infection (HAI) surcharge on a county nursing facility's licensing fee is an allowable cost under the MA Program. The MA portion of the HAI surcharge will be reimbursed as a pass-through payment and will be paid on an annual basis. A nursing facility's annual HAI pass-through payment will equal the annual HAI surcharge fee paid by the nursing facility, less any penalties assessed, as verified by the DOH, multiplied by the nursing facility's MA occupancy rate as reported on the nursing facility's cost report for the fiscal year in which the annual HAI surcharge is paid. The HAI pass-through payment will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before the later of 210 days from the close of the nursing facility fiscal year or the date on which the DOH received payment of the nursing facility's HAI surcharge fee.

G. Cost Finding

All county nursing facilities participating in the MA Program must allocate costs between nursing facility services and non-nursing facility services in accordance with the allocation bases established or approved by the Department.

All county nursing facilities participating in the MA Program shall use the direct allocation method of cost finding. Under this method of cost finding. costs are apportioned directly to the nursing facility and residential or other facility based on the appropriate ·financial and statistical data.

H. Cost Reporting and Audit Requirements

County nursing facilities participating in the.MA Program shall report allowable costs and the results of the cost finding process on forms specified by the Department. All records are subject to verification and audit. The financial and statistical records of county nursing facilities are audited periodically by either the Department or the Auditor General.

A county nursing facility shall hold, safeguard and account for residents' personal funds upon written authorization from the resident in accordance with all applicable provisions of State and Federal law. Residents' personal fund accounts are audited periodically by the Department.

I. Hospice Services

If an MA recipient residing in a county nursing facility is dually eligible for Medicare Part A services and elects to receive hospice services in lieu of nursing facility services, as applicable, the MA Program pays a Medicare-certified hospice provider an amount equal to the room and board payment made to the nursing facility as part of the nursing facility services and will discontinue direct payment to the nursing facility for services. The hospice provider, in order to receive payment from the Department, shall enter into an agreement with the county nursing facility by which the hospice provider agrees to assume full responsibility for the recipient's hospice care and the nursing facility agrees to provide room and board to the recipient (See Attachment 4.19B, Item #21).

J. Related Provisions

1. Supplement I contains the Department's Chapter 1189 County Nursing Facility Services Regulations.

2. Supplement II of Attachment 4.190, Part I contains the upper payment limit phase. out for State fiscal years 2003-2004 through 2009-2010.

3. The Commonwealth of Pennsylvania has in place a process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Methods and Standards for Governing Payment for County Nursing Facility Services

Citation

42 CFR 447, 434,438, and 1902(a)(4), 1902(a}(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions (OPPCs)

The Department identifies the following OPPCs for non-payment under Section{s) 4.19D.

___X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section{s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.

(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) Reductions in provider payment may be limited to the extent that the following apply:

a. The identified ppe will otherwise result In an Increase in payment.

b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

CHAPTER 1189.
COUNTY NURSING FACILITY SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. ALLOWABLE PROGRAM COSTS AND POLICIES

SUBCHAPTER C. COST REPORTING AND AUDIT REQUIREMENTS

SUBCHAPTER D. RATE SETTING

SUBCHAPTER E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

SUBCHAPTER F. RIGHT OF APPEAL

Subchapter A. GENERAL PROVISIONS

§ 1189.1. Policy.

(a) This chapter applies to county nursing facilities.

(b) This chapter sets forth conditions of participation for county nursing facilities, identifies the costs incurred by county nursing facilities to provide nursing facility services that will be recognized as allowable MA Program expenditures and specifies the methodology by which rates will be set and payments made to county nursing facilities for services provided to MA residents.

(c) Payment for nursing facility services provided by county nursing facilities is made subject to this chapter and Chapter 1101 (relating to general provisions).

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of a cost report, resident assessment data and picture date reporting, or other document or submission to the Department cannot be extended, except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed by this chapter may be permitted only upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

§ 1189.2. Definitions.

(a) Except for those terms defined in subsection (b), the defined words and terms set forth in § 1187.2 (relating to definitions), have the same meanings when used in this chapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Allowable MA Program Expenditure—A cost incurred by a county nursing facility to provide nursing facility services to MA residents that is allowable under this chapter and that is reported and certified by the county nursing facility in a form and manner specified by the Department.

MA Cost Report—The package of certifications, schedules and instructions designated by the Department which county nursing facilities shall use to record and report the costs that they incur to provide nursing facility services during a calendar year.

New county nursing facility - A newly constructed, licensed and certified county nursing facility; or an existing nursing facility that through a change of ownership, is controlled by the county institution district or by county government if no county institution district exists.

Per diem rate—The amount established under this chapter at which the Department makes payment to a county nursing facility for a resident day of care provided to an MA resident.

§ 1189.3. Compliance with regulations governing noncounty nursing facilities.

(a) Unless a specific provision of this chapter provides to the contrary, the following subchapters of Chapter 1187 (relating to nursing facility services) are applicable to county nursing facilities:

(1) Subchapter B (relating to scope of benefits).

(2) Subchapter C (relating to nursing facility participation).

(3) Subchapter D (relating to data requirements for nursing facility applicants and residents), except for § 1187.33(b) (relating to resident data and picture data reporting requirements).

(4) Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(5) Subchapter K (relating to exceptional payment for nursing facility services).

(b) If a provision of Chapter 1187 is made applicable to county nursing facilities by subsection (a) or other provision of this chapter, and the provision of Chapter 1187 uses the term ‘‘nursing facility,’’ that term shall be understood to mean ‘‘county nursing facility,’’ unless the context clearly indicates otherwise.

Subchapter B. ALLOWABLE PROGRAM COSTS AND POLICIES

§ 1189.51. Allowable Costs

A cost incurred by a county nursing facility is an allowable cost if the cost was incurred in the course of providing nursing facility services; and

(1) The cost is allowable pursuant to the Medicare Provider Reimbursement Manual (CMS Pub.15-1) Of,

(2) The cost is not allowable pursuant to the CMS Pub.15-1 but is allowable as a net operating cost pursuant to Chapter 1187; or,

(3) The cost is identified as an allowable county nursing facility cost in the Commonwealth's approved State Plan.

§ 1189.52. Allocating cost centers.

(a) The county nursing facility shall allocate costs in accordance with the allocation bases and methodology established by the Department as contained in this chapter and the MA cost report. If the nursing facility has its own more accurate method of allocation basis, it may be used only if the nursing facility receives written approval from the Department prior to the first day of the applicable cost report year.

(b) The absence of documentation to support allocation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved changes in bases shall result in disallowances being imposed for each affected line item.

§ 1189.53. Changes in bed complement during a cost reporting period.

(a) When the county nursing facility's bed complement changes during a cost reporting period, the allocation bases are subject to verification at audit.

(b) The county nursing facility shall keep adequate documentation of the costs related to bed complement changes during a cost reporting period. The county nursing facility shall submit the supplemental schedules as may be required by the Department to identify the costs being allocated by the required statistical methods for each period of change.

§ 1189.54. Costs of related parties.

Costs applicable to services, movable property and supplies, furnished to the county nursing facility by organizations related to the county nursing facility by common ownership or control shall be included as an allowable cost of the county nursing facility at the cost to the related organization. This cost may not exceed the price of comparable services, movable property or supplies that could be purchased elsewhere.

§ 1189.55. Prudent buyer concept.

The purchase or rental by a county nursing facility of services, movable property and supplies, including pharmaceuticals, may not exceed the cost that a prudent buyer would pay in the open market to obtain these items, as described in the CMS Pub. 15-1.

Subchapter C. COST REPORTING AND AUDIT REQUIREMENTS

§ 1189.71. Cost reporting.

(a) A county nursing facility shall submit an acceptable MA cost report to the Department within 120 days following the close of each calendar year in a form and manner specified by the Department. Requests for an extension to file an annual cost report will not be granted except as provided under § 1189.1 (relating to policy).

(b) An acceptable MA cost report is one that meets the following requirements:

(1) Applicable items are fully completed in accordance with the instructions provided for the cost report including the necessary original signatures on the required number of copies.

(2) Computations carried out on the cost report are accurate and consistent with other related computations.

(3) The treatment of cost conforms to the applicable requirements of this chapter.

(4) Required documentation is included.

(5) The cost report is filed with the Department within the time limits specified.

§ 1189.72. Cost reporting for Medicare Part B type services.

(a) County nursing facilities shall utilize Medicare as a primary payer resource when appropriate, under § 1189.102 (relating to utilizing Medicare as a resource).

(b) If Medicare is the primary payer resource, the county nursing facility shall exclude from allowable costs operating costs incurred in or income derived from the provision of Medicare Part B coverable services to nursing facility residents. The county nursing facility shall attach to the MA cost report a copy of the cost report the nursing facility submits to Medicare for the Part B services and, when available, submit a copy of the Medicare final audit, including audit adjustments.

(c) If there is a discrepancy between the costs on the Medicare cost report or, if available, the Medicare audit report, and the adjustments made by the county nursing facility on the MA cost report to exclude Medicare Part B costs, the Department will make the necessary adjustments to conform the county nursing facility's MA cost report to the Medicare report.

§ 1189.75. Auditing requirements related to MA cost report.

(a) The Department will conduct an audit of each acceptable MA cost report with an end date of December 31, 2005, and thereafter to determine the county nursing facility's allowable MA Program expenditures for the calendar year.

(b) To determine the county nursing facility's audited allowable MA Program expenditures for a calendar year, the Department will audit the county nursing facility's MA cost report for compliance with:

(1) This chapter.

(2) Chapter 1101 (relating to general provisions).

(3) The schedules and instructions included in the MA cost report.

(c) A county nursing facility shall make financial and statistical records to support its MA cost reports available to the Department upon request and to other State and Federal representatives as required by Federal and State law and regulations.

(d) The Department will conduct audits in accordance with auditing requirements in Federal regulations and generally accepted government auditing standards.

(e) A county nursing facility that has certified financial statements, Medicare intermediary audit reports with adjustments and Medicare reports for the reporting period shall submit these reports with its cost report, at audit or when available.

Subchapter D. RATE SETTING

§ 1189.91. Per diem rates for county nursing facilities.

(a) For the rate year 2006-2007, the per diem rate paid to a county nursing facility for a rate year will be the facility's April 1, 2006, case-mix per diem rate as calculated under Chapter 1187, Subchapter G (relating to rate setting) multiplied by a budget adjustment factor determined in accordance with subsection (d).

(b) For each rate year beginning on or after July 1, 2007, the per diem rate paid to a county nursing facility for a rate year will be the facility's prior rate year per diem rate multiplied by a budget adjustment factor determined in accordance with subsection (d).

(c) The Department, at its discretion, may revise the per diem rates for county nursing facilities by calculating updated case-mix per diem rates in accordance with Chapter 1187, Subchapter G or under an alternative method specified in the Commonwealth's approved State Plan.

(d) The budget adjustment factor for the rate year will be determined in accordance with the formula in the Commonwealth's approved State Plan.

§ 1189.92. Per diem rates for new county nursing facilities.

The per diem rate for a new county nursing facility will be the Statewide average of all other county nursing facilities' per diem rates for the same rate year established in accordance with § 1189.91 (relating to per diem rates for county nursing facilities).

Subchapter E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1189.101. General payment policy for county nursing facilities.

(a) Payment for nursing facility services provided by a county nursing facility will be made subject to the following conditions and limitations:

(1) This chapter and Chapter 1101 (relating to general provisions).

(2) Applicable State statutes.

(3) Applicable Federal statutes and regulations and the Commonwealth's approved State Plan.

(b) A per diem rate payment for nursing facility services provided by a county facility will not be made if full payment is available from another public agency, another insurance or health program or the resident's resources.

(c) Payment will not be made in whole or in part to a county nursing facility for nursing facility services provided during a period in which the nursing facility's participation in the MA Program is terminated.

(d) Claims submitted by a county nursing facility for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101. In addition, the Department will perform the reviews specified in this chapter for controlling the utilization of nursing facility services.

§ 1189.102. Utilizing Medicare as a resource.

(a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified county nursing facility and is authorized by the Medicare Program to receive county nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the county nursing facility's MA per diem rate for

nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the county nursing facility. The Department will not pay more than the maximum coinsurance amount.

(b) If a resident has Medicare Part B coverage, the county nursing facility shall use available Medicare Part B resources for Medicare Part B services before payment is made by the MA Program.

(c) The county nursing facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible resident because of the limit of the county nursing facility's MA per diem rate.

(d) The Department will recognize the Medicare payment as payment in full for each day that a Medicare payment is made during the Medicare-only benefit period.

(e) The cost of providing Medicare Part B type services to MA residents not eligible for Medicare Part B services which are otherwise allowable costs under this part are reported in accordance with § 1189.72 (relating to cost reporting for Medicare Part B type services).

§ 1189.104. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a county nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the county nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents is certifiable and licensed to provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring county nursing facility provider number as long as the transferring county nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring county nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The county nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§ 1189.105. Incentive payments.

(a) *Disproportionate share incentive payment.*

(1) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(i) The county nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(ii) The county nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(2) The disproportionate share incentive payments will be based on the following:

	Overall *Occupancy*	MA *Occupancy (y)*	Per Diem *Incentive*
Group A	90%	›= 90% y	$3.32
Group B	90%	88% ‹= y ‹90%	$2.25
Group C	90%	86% ‹= y ‹88%	$1.34
Group D	90%	84% ‹= y ‹86%	$0.81
Group E	90%	82% ‹= y ‹84%	$0.41
Group F	90%	80% ‹= y ‹82%	$0.29

(3) The disproportionate share incentive payments as described in paragraph (2) will be inflated forward using the first quarter issue CMS Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(4) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before 210 days of the close of the county nursing facility fiscal year.

(5) For the period July 1, 2005, to June 30, 2009, the disproportionate share incentive payment to qualified county nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with paragraph (3).

(i) For the period commencing July 1, 2005, through June 30, 2006, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2005.

(ii) For the period commencing July 1, 2006, through June 30, 2007, the increased

incentive applies to cost reports filed for the fiscal period ending December 31, 2006.

(iii) For the period commencing July 1, 2007, through June 30, 2008, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2007.

(iv) For the period commencing July 1, 2008, through June 30, 2009, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2008.

(b) *Pay for performance incentive payment.* The Department will establish pay for performance measures that will qualify a county nursing facility for additional incentive payments in accordance with the formula and qualifying criteria in the Commonwealth's approved State Plan.

§ 1189.106. Adjustments relating to sanctions and fines.

County nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1189.107. Adjustments relating to errors and corrections of county nursing facility payments.

County nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and § 1189.141 (relating to county nursing facility's right to appeal and to a hearing).

§ 1189.108. County nursing facility supplementation payments.

Supplementation payments are made according to a formula established by the Department to county nursing facilities, in which Medicaid funded resident days account for at least 80% of the facility's total resident days and the number of certified MA beds is greater than 270 beds. Payment of the supplementation payments is contingent upon the determination by the Department that there are sufficient State and Federal funds appropriated to make these supplementation payments.

Subchapter F. RIGHT OF APPEAL

§ 1189.141. County nursing facility's right to appeal and to a hearing.

(a) A county nursing facility has a right to appeal and have a hearing if the county nursing facility does not agree with the Department's decision regarding:

(1) The Department's denial, nonrenewal or termination of the county nursing facility's MA provider agreement.

(2) The Department's imposition of sanctions or fines on the county nursing facility under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) of Chapter 1187 (relating to nursing facility services).

(3) The per diem rate established by the Department.

(4) Any other written order or decision of the Department that causes the county nursing facility to be aggrieved for purposes of Chapter 11 of Title 67 of the Pennsylvania Consolidated Statutes (relating to Medical Assistance hearings and appeals).

(b) A county nursing facility appeal is subject to § 1101.84 (relating to provider right of appeal).

(c) If a county nursing facility wishes to contest any of the decisions listed in subsection (a)(1)(4), it shall file a request for hearing within the time limits set forth in Chapter 11 of Title 67 of the Pennsylvania Consolidated Statutes.

(d) A county nursing facility's appeal is subject to the requirements set forth in Chapter 11 of Title 67 of the Pennsylvania Consolidated Statutes and the standing practice order of the Bureau of Hearings and Appeals, or in any regulations that supersede the standing practice order.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

Categories of Recipients

Pennsylvania has established its Medical Assistance Long Term Care Program based on recipient characteristics, and the special service needs of the recipients. One of the categories of recipients. is mentally retarded persons and persons with similar conditions, who by reason of their dysfunction, require higher levels of supporting and ancillary services in addition to care normally provided in a nursing facility. Persons with other related conditions are persons with severe physical disabilities~ such. as cerebral palsy, spina bifida, epilepsy or other similar conditions which are diagnosed prior to age 22 and result in at least three substantial limitations to activities of daily living.

Classes of Long-Term Care Facilities

For purposes of reimbursement, long term care facilities are grouped in various classes based on the category of recipient need: One statewide class is intermediate care facilities providing long term care for mentally retarded persons (ICFs/HR), including ICFs/HR for persons with other related conditions (ICFs/ORC). ICFs/Hi include state operated ICFs/MR, non-State operated ICFs/MR, and intermediate care facilities providing long term care for persons with other related conditions (ICFs/ORC).

Methods and Standards for Reasonable Cost-Related Reimbursement for Intermediate Care Facilities for the Mentally Retarded and Persons with Related Conditions

Cost Finding

State-operated ICFs/MR

All state-operated ICF/MR facilities participating in the Medical Assistance program are required to use the direct allocation method of cost finding. Under this method of cost finding, net operating costs, as defined by regulations, are allocated between nursing services and non-nursing services based upon statistical data. Allowable depreciation and interest on capital indebtedness is identified by facility and is also allocated to nursing and non-nursing services based upon specified statistical data.

Allowable depreciation and interest on capital indebtedness is identified by facility and is also allocated to nursing and non-nursing services based upon specified statistical data.

Allowable costs and the results of the cost finding process are reported electronically on forms specified by the Department of Public Welfare. All facilities are required to maintain records for a minimum of four years.

Non-State ICFs/MR and ICFs/ORC

All non-state ICFs/M.R and ICFs/ORC, are required to use the direct allocation method of cost finding. For purposes of Medical Assistance reimbursement, the return on net equity and net worth is not reimbursable.

For non-state ICFs/HR and ICFs/ORC, allowable costs and the results of the cost finding process are reported on forms specified by the Department of Public Welfare. All facilities are required to maintain records for a minimum of four years following submission of the report.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

Rate Setting

Separate rates of reimbursement are established for intermediate care facilities for the mentally retarded (ICFs/MR) and ICFs/ORC based on cost finding performed for each facility in that class.

State-Operated ICFs/MR

State operated ICFs/MR are reimbursed for their actual allowable net operating costs. This is done in recognition of the unique service needs of recipients in these facilities.

Non-State Operated ICFs/MR and ICFs/ORC

Non-state operated ICFs/MR and ICFs/ORC are reimbursed actual allowable costs up to the limit of a total projected operating cost or an approved budget level set in accordance with 55Pa. Code Chapter 6211.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

For non-state ICFs/MR and ICFs/ORC, allowable reimbursement for depreciation and interest is included within the limits of the total projected operating cost, or the approved budget level in accordance with Chapter 6211, Section 6211.41.

An efficiency incentive is allowable for non-state ICFs/MR and ICFs/ORC in accordance with Chapter 6211, Section 6211.17.

Payments

State-Operated ICFs/MR

Payments are made to each state-operated ICF/MR facility based on an interim per diem rate multiplied by number of days of care provided to eligible clients. At the close of the facility's year, payments are adjusted to reflect allowable costs as established for state operated ICF/MR facilities, and an interim settlement is effected. All of these facilities are reviewed on a fiscal year basis by an independent agency, and upon completion of the audit, a final settlement payment is completed.

Non-State Operated ICFs/MR and ICFs/ORC

Payments are made to non-state ICFs/MR and ICFs/ORC based on an interim per diem rate, multiplied by the number of days of service provided to eligible recipients. At the close of the fiscal year, following audit and final cost settlement, each facility will be reimbursed allowable operating costs, including allowable depreciation and interest on capital indebtedness, up to the approved total projected operating cost, or if a waiver of the standard interim rate was granted, allowable costs will be reimbursed up to the limit of an approved budget, in accordance with 55 PA Code Ch 6211, Section 6211.18 and 6211.34.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

Allowable Cost Standards

State-Operated ICFs/MR

In identifying items of allowable costs for state-operated facilities for mentally retarded persons, Pennsylvania's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" (Manual) will be used where applicable.- If the Manual does not address a particular cost, the Federally approved Departmental Indirect Cost Allocation Plan/Statewide Indirect Cost Allocation Plan (DICAP/SWICAP) will be followed. If none of these addresses a particular cost, Medicare full cost principles will be used.

Non-State Operated ICFs/MR and ICFs/ORC

Allowable costs for non-state operated ICFs/MR and ICFs/ORC are defined in Chapter 6211, Allowable Cost Reimbursement for non-State Operated ICFs/HR. -In addition to Chapter 6211, the Medicare Provider Reimbursement Manual (HIM-15) also applies for costs that are included in Chapter 6211 as allowable and for reimbursable costs that are not specifically addressed in Chapter 6211. If Chapter 6211 is inconsistent with HIM-15, Chapter 6211 prevails.

For non-state ICFs/HR and ICFs/ORC, depreciation and interest are reimbursed inclusively, and applicable limits are contained in Chapter 6211, Section 6211.79 and 6211.81.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

Auditing

State-Operated ICFs/MR

The financial and statistical records for state-operated ICF/HR facilities are audited annually In accordance with Government Auditing. Standards by the Comptroller's Office, and allowable financial costs relating to medical assistance are adjusted accordingly.

Non-State Operated ICFs/MR and ICFs/ORC

For non-state ICFs/MR and ICFs/ORC, the financial and statistical records for each facility are verified annually by the Department's Bureau of Financial Operations through either a desk review or a field audit.

Final cost settlement for each facility is limited allowable costs as determined by either the desk review or field audit.

Methods and Standards for Reasonable Cost-Related
Reimbursement for Intermediate Care Facilities for the Mentally
Retarded and Persons with Related Conditions

Related Provisions

Supplement I is the Department's regulations: Chapter 6211, governing rate setting and reimbursement to non-state ICFs/MR and ICFs/ORC.

Methods and Standards for Reasonable Cost-Related Reimbursement for Intermediate Care Facilities for the Mentally Retarded and Persons with Other Related Conditions

Citation

42 CFR 447,434,438, and 1902(a)(4}, 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR' Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19D

__X____ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner.

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other Invasive procedure on wrong body part), PB (surgical or other invasive procedure. on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.

(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior [0 the initiation of treatment for that patient by that provider.

(2) Reductions in provider payment may be limited to the extent that the following apply:

a. The identified PPC will otherwise result in an increase in payment.

b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC,

(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Methods and Standards for Reasonable Cost-Related Reimbursement for State Operated, Nursing Facilities

Reimbursement

Cost Finding

All state-operated nursing facilities participating in the Medical Assistance program, including state veterans homes which are operated solely for the purpose of providing long term care-for veterans and their spouses who are disabled, chronically ill, or in need of specialized care, are required to use the direct allocation method of cost finding. Under this method to cost finding, net operating costs are allocated between nursing facility services and non-nursing facility services based on specified statistical data.

Allowable depreciation and Interest on capital indebtedness is Identified by facility and is also allocated to nursing and non-nursing services based upon specified statistical data.

Allowable costs and the results of the cost finding process are reported electronically on forms specified by the Department of Public Welfare: All facilities are required to maintain records for a minimum of four years.

Rate Setting

Separate rates of reimbursement are established for state-operated nursing facilities based on the cost finding performed for each facility in that class. State-operated nursing facilities employ a single rate based on the actual allowable costs. Applicable depreciation and interest" on capital Indebtedness is incorporated as an allowable element of a single rate.

Payments

Payments-ar-e-made-to-eaoh-state-operated-nursing-facllllty-based-on-an-interim-per-diem rate multiplied by number of days of care provided to eligible clients. At the close of the facility's year, payments are adjusted to reflect allowable costs as established for state-operated nursing facilities, and an Interim settlement is effected. All of these facilities are reviewed on a fiscal year basis by an independent agency, and upon completion of the audit, a final settlement payment Is completed.

Allowable Cost Standards

In Identifying Items of allowable costs for state-operated nursing facilities, Pennsylvania's "Cost Apportionment Manual for State Menta! Hospitals and Mental Retardation Centers" (Manual) will be used where applicable. If the Manual does not address a particular cost, the federally approved Departmental Indirect Cost Allocation Pian/Statewide Indirect Cost Allocation Plan (DICAP/SWICAP) will be followed. If none of these addresses a particular cost, Medicare full cost principles will be used.

Methods and Standards for Reasonable Cost-Related Reimbursement for State Operated, Nursing Facilities

Reimbursement

Auditing

The financial and statistical records for state-operated nursing facilities are completed annually In accordance with Government Auditing Standards by the Comptroller's Office and allowable financial costs relating to Medical Assistance are adjusted accordingly.

Methods and Standards for Reasonable Cost-Related Reimbursement for State Operated, Nursing Facilities

Payments

Payments are made to each state-operated psychiatric aftercare nursing facility based on an interim per diem rate multiplied by number of days of care provided to eligible clients. At the close of the facility's year, payments are adjusted to reflect allowable costs as established for state-operated psychiatric aftercare nursing facilities, and an interim settlement is effected. All of these facilities are reviewed on a fiscal. year basis by an independent agency, and upon completion of the audit, a final settlement payment is completed.

Allowable Cost Standards

In identifying items of allowable costs for state-operated psychiatric aftercare nursing facilities, Pennsylvania's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" (Manual) will be used where applicable. If the Manual does not address a particular cost, the federally approved Departmental Indirect Cost Allocation Plan Statewide Indirect Cost Allocation Plan (DICAP/SWICAP) will be followed. If none of these addresses a particular cost, Medicare full cost principles will be used.

Auditing

The financial and statistical records for state-operated psychiatric aftercare nursing facilities are audited annually in accordance with Government Auditing Standards by the Comptroller's Office, and allowable financial costs relating to Medical Assistance are adjusted accordingly.

Note: Attachment 4.19D Part III includes pages 1, 2, 3, and 14. While Page 14 was approved by CMS, the page numbering was a typo – Page 14 should have been numbered page 4. Accordingly, pages 4 through 13 are not missing – they never existed. Page 14 is really page 4.

Methods and Standards for Reasonable Cost-Related Reimbursement for State Operated Nursing Facilities

Citation

42 CFR 447,434,438, and 1902(a)(4}, 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19D

__X____ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner.

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other Invasive procedure on wrong body part), PB (surgical or other invasive procedure. on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.

(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior [0 the initiation of treatment for that patient by that provider.

(2) Reductions in provider payment may be limited to the extent that the following apply:

a. The identified PPC will otherwise result in an increase in payment.

b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC,

(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

LISTING OF PSYCHIATRIC AFTERCARE NURSING FACILITIES

Clarks Summit LTC Unit

Danville LTC Unit

Haverford LTC Unit

Mayview LTC Unit

Torrance LTC Unit

Wernersville LTC Unit

South Mountain Restoration Center